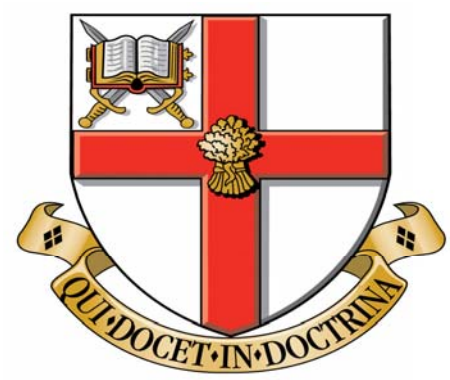

University of Chester

Using a feminist standpoint to explore women's disclosure of domestic violence and their interaction with statutory agencies.

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor of Philosophy by June Jean Keeling

November 2011

Declaration by Candidate

I hereby declare that this thesis is my own work and effort and that it is has not been submitted elsewhere for any award. Where other sources of information have been used, they have been acknowledged.

Signature:…….

Date:……..

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Acknowledgments

Throughout this journey there have been many people who have provided support, offered advice and shared words of wisdom. I give you my sincere thanks for without each one of you I might not now be completing this.

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Using a feminist standpoint to explore women's disclosure of domestic violence and their interaction with statutory agencies

June Jean Keeling

Abstract

This thesis explores women's disclosure of domestic violence, and is based on the findings of two research studies. The first study explored prevalence rates of domestic violence reported by women following childbirth. The subsequent narrative study explored women's experiences of disclosure and their interactions with statutory agencies. The research was influenced by a feminist epistemology, recognizing the marginalisation of the women's experiences from a subjugated relationship, addressing the power relationship between the researcher and participants and because of the significant disparity between gendered lives.

The study was conducted in two parts. A survey of five hundred women in the immediate postnatal period within a large NHS Hospital participated in the first part of the study. The second study involved narrative interviews with fifteen women living within their own community who talked about their experiences of domestic violence and issues surrounding disclosure. Women's stories about disclosure including the responses they received were influenced by cultural narratives. The theories of social power have been utilized as an explanatory framework and provide the theoretical basis of the analysis.

The study found low levels of disclosure at two specific points along the pregnancy/childbirth continuum; during booking in clinic and in the immediate postnatal period. Furthermore, the findings revealed three specific tactics used by perpetrators to engage women in the early relational stage with the intentionality of exerting control and subjugation. These have been termed feeling special, feeling vulnerable and commitment. Whilst women talked of coercion and subjugation by their partners, they also talked of how their interactions with statutory agencies limited their agency.

The significance of this study is that the thesis was able to challenge contemporary policies developed by statutory agencies in the provision of support to women who experience domestic violence. The thesis develops some understanding of the nature and role of cultural narratives and patterns of disclosure before suggesting new directions to further advance the findings presented. Finally, the thesis proposes recommendations to improve training for statutory agencies in providing a response to women disclosing domestic violence, suggesting a new direction in thinking about the facilitation of this training.

Chapter One: Introduction and Background

1.1 Experiences and personal location

I commence this thesis by detailing the events that led me to become interested in the subject of domestic violence perpetrated against women. This interest emerged whilst I was working as a midwife. There were two specific instances in practice, whereby I had a 'hunch' that the relationship dynamics were unequal, to the detriment of the woman.

Practice Experience 1: As a midwife working within the community, I visited a woman at home who was five days postpartum. Whilst I was doing a postnatal examination, I noticed that her perineal sutures had been removed. She had not offered this knowledge prior to her examination, and it was only when I made enquiries that she informed me her husband had decided to remove them as they were painful. When I then left the room, I found her partner kneeling outside the bedroom door, appearing to have been listening in to our conversation. Afterwards, he answered all my questions, even though they were directed at the woman, and I made eye contact with her, not him.

Practice Experience 2: Whilst on the postnatal ward, I spent some time talking to a young woman who had delivered twins at home. She was distressed about the rapid and unsupervised delivery of the babies, and that her partner had shouted abusive comments at her throughout this experience. I also noticed that each time her male partner visited, he closed the curtains around the women's bedside area, leaving them closed throughout his visit. At the end of visiting, I observed a change in the woman's behaviour as she became more withdrawn.

Despite engaging these women in a conversation about domestic violence and signposting to other agencies, neither woman disclosed. I acknowledge that whilst I cannot prove that domestic violence was present in their relationships, it was clearly evident that there was an imbalance with the relationship, with both male partners making decisions on behalf of the women.

From these experiences, I began to question other relationships I had observed following the delivery of a baby, whereby the male partner appeared to 'take control' of the woman and her decisions, with the woman remaining silent. This then formed the platform from which this PhD was built, seeking to explore the issue of disclosure of domestic violence, and further, attempting to illuminate women's actual experiences and providing them with a forum through which they could be heard. I had a genuine interest in hearing these women's stories, as it was apparent to me as a midwife, that their male partners were a dominant partner within their relationship.

The importance of conceptualising my entry point into this PhD study is crucial to identifying the approaches I have chosen. I begin by making explicit my ontological stance, and then discussing my epistemological stance and the theoretical perspective that has been utilised in the analysis.

The ontological stance of the researcher acts as a guide, drawing the researcher towards a subject in which the researcher has an affinity (Nicholson, 1990). Haraway (1988) adds to this arguing that our personal positionality offers us a unique way of viewing the world, in ways that others cannot. Ontology is the way we understand the world and the assumptions we make about the nature of reality (Crotty, 1998). My ontological view posits around the

notion that women live within an unequal society, experiencing multiple repressive and oppressive practices. However it is from within these experiences and from experiencing this oppression, that we can generate more accurate knowledge as they have lived it. Ramazanoglu and Holland (2008) argue that feminist knowledge then becomes grounded in women's lives revealing how it feels to live in an unequal gendered relationship. In making explicit what I believe about gender and power, I identify my ontological stance as one of critical realism. This then, illuminates my world view as one in which I believe each individual's persona and beliefs have originated from and been affected by, their life's journey and socio-cultural experiences. This implicit nature of knowledge, derived from women's 'concrete experiences' (Brooks, 2007: 56), is essential in the production of accurate and authentic knowledge.

Feminist Standpoint epistemology is a way of 'exposing real relations of gender subordination as unjust' and has implications for the relationship between knowledge and power (Ramazanoğlu & Holland, 2008: 68). I draw on Hartstock's (1997b) and Harding's (1993) work, identifying a feminist standpoint epistemology as a position from which women who experience subjugation, share a vantage point on the use of power and illuminate specific knowledge from these experiences. The way in which I have utilised this epistemology is discussed further in chapter three.

My choice of theory has been based on my belief that inequalities between women and men are based on the use of patriarchal power derived from living within a patriarchal society. Therefore, I have chosen Raven's (1992) elaboration on the theory of social power (French & Raven, 1959) as the theoretical perspective, accepting that power is conceptualized as more than physical threats. Acknowledging that there are also complex organisational and

ideological forces affecting statutory agency responses to women experiencing domestic violence, my analysis also draws on Foucault's work, exploring power at an institutional level.

1.2 Plan of the thesis

This PhD thesis is composed of two related studies. Using opposing paradigms, it is necessary to make explicit the inter-relationship between these two studies.

The first study, a survey, explored the prevalence rates of domestic violence reported by women following childbirth. This study revealed a disparity in the reporting rates of domestic along the pregnancy/childbirth continuum (see chapter four). To explore this phenomenon further, a subsequent study using a narrative approach to interviewing was chosen, in the anticipation that the women would include talk of their experiences of disclosure in the interview.

This thesis is primarily concerned with understanding the dynamics of disclosure of domestic violence, and how women negotiate their interactions with statutory agencies within contemporary society. Historically domestic violence has been considered a private problem, rather than a societal issue (Stark, Flitcraft, & Frazier, 1979) and thus has been largely ignored by statutory agencies. However the feminist movement has striven to juxtapose the experiences of women with the inequalities of the social justice system, leading to a growing body of knowledge and action in this arena. This thesis argues that despite the development by statutory agencies of policies and recommendations aimed at improving the responses to women disclosing domestic violence, it is often the personal attributes of the statutory employees that underpin the negative responses to women who choose to disclose.

1.3 Study objectives

The study had **two aims**. The first was to explore the prevalence rates of domestic violence reported by women in the postnatal period. These rates were then compared to previously collected data, in which the methodology was replicated and the samples drawn from the same geographical area. The second aim was to explore women's disclosure of domestic violence and their interaction with statutory agencies, affording a greater understanding of the issues underpinning these statistical results. The focus of the research moved to the women themselves to hear their previously untold stories of subjugation, coercion and violence.

Therefore the principal **objectives** of this research study were:

1. To explore the reporting rates of domestic violence in a sample of postnatal women, and compare these rates to previous studies.
2. To explore women's accounts of disclosure of domestic violence.
3. To explore the interaction of statutory agencies and women disclosing domestic violence.
4. To present the women's experiences in their own words to a wider audience through publications, conference presentations and seminars.

1.4 Structure of the thesis

In this section I present a précis of the chapters within this PhD thesis. Whilst this chapter provides a background and introduction to the subject and the research, the subsequent chapters build on this knowledge, providing a backdrop for the research findings. Two research studies using opposing paradigms are presented in the thesis. Whilst there is a consistency between both studies in terms of epistemology and theoretical framework, there are significant differences in the methods, data collection and data analysis. The following

précis of the chapters illuminates how the connections between these two studies will be addressed in the thesis.

Chapter two presents a synthesis of the literature, commencing with an overview of domestic violence from a global perspective, and then explores the subject in relation to the United Kingdom. Contemporary social and governmental policies and practices for addressing domestic violence within this country are discussed, as it appears that it is responses from statutory agency workers, directed towards women experiencing domestic violence in contemporary society, that maintain the dichotomous approach of domestic violence being a private issue rather than a public one. Additionally, this chapter draws on work surrounding disclosure of domestic violence, and explores both extrinsic and intrinsic factors before identifying the disagreements within the literature.

Chapter three examines the research design and methodology of both of the research studies. It commences with a discussion on the application of feminist research, progressing to include standpoint feminism. It discusses the constitution of feminist research, and explores the potential benefits of embracing this epistemological stance to research women's experiences of subjugation and coercion within a relationship in which domestic violence features. This chapter argues that a feminist epistemology seeks to neutralise the dominance of the researcher found in traditional interview techniques, thus focusing more than other research methods on the stories of women. Moreover, this may be considered an empowering social science methodology, giving women more opportunity to articulate their own viewpoints (Gubrium & Holstein, 2009) and thus hearing the stories of subjugated women. At this point, it then addresses components of each study separately, exploring specific aspects related to each study. However from section 3.3 onwards, the two studies are woven

together as I present comparable aspects of both studies under the same subheading where relevant. I provide a rationale for the studies being influenced by a feminist epistemology, and explain how I entered the field for both studies and negotiated access to the women. Additionally, ethical dilemmas are discussed and the process of obtaining ethical consent for both studies is detailed. To conclude, the chapter seeks to illuminate how a feminist framework was applied to this research and to hear and understand subjugated women's stories of domestic violence within the social context.

In chapter four I present the findings from the quantitative study exploring the reporting rates of domestic violence in women within the immediate postnatal period. Whilst these rates were similar to those previously reported in literature, this study replicated the methodology of previous studies in which the sample was drawn from the same geographical area. This resulted in the comparison of data from four different points along the pregnancy/childbirth continuum, and it is here that an interesting phenomenon was revealed. These four points in pregnancy include the Booking In Clinic, Early Pregnancy unit, Pregnancy Counselling Clinic and the immediate postnatal period.

The second study returned to the women themselves, to hear their own intimate stories. Contextualising these stories, table 7 in chapter five offers a précis of each participant involved in the second qualitative research study, for the narrative excerpts presented in chapters five to eight.

I commence my analysis of the narrative study in chapter five with the women's stories of how their relationships began and then evolved into a cycle of coercion and subjugation. The women's narratives reveal three tactics (feeling special; feeling vulnerable and commitment)

used by their male partners to successfully engage and retain them within a relationship with the intention of exerting control, inflicting violence and subjugation. Their experiences during the transition within their relationship, from love to violence, are also highlighted. Many of the women chose to share their intimate stories about this initial engagement within a relationship and their experiences of the coercive and controlling behaviours – physical violence, intimidation, threats and sexual violence – used by their perpetrators. When combined, these narratives extended beyond the speaker, representing powerful illustrations of subjugation and domination by an intimate partner.

Chapter six continues the analysis of the women's talk, exploring their experiences of interactions with health care providers, both during pregnancy and afterwards. In relation to the quantitative study discussed in chapter four, this chapter provides meaning to some of the statistical data. The chapter includes an exploration of why women are reticent to disclose domestic violence when accessing the health care system, and how the abuse impacts on choices in motherhood such as how these mothers choose to feed their newborn babies.

Social workers are an integral provider in the statutory support offered to women experiencing domestic violence. Chapter seven uses information obtained from the women's personal narratives to examine this social worker-client relationship, and it is evident that the women experience fear with a perception of being threatened by the potential involvement of this statutory agency, leading to a concealment of experiences and the potential for further abuse by the perpetrator. The parallels between such reported forms of coercion employed by social workers and those used by the abuser are striking.

Chapter eight presents my analysis of the women's stories of their experiences of the interaction with the first response officers following an incident of domestic violence. The police are often the first professionals to attend an incident involving domestic violence within the home, and their interaction and response may underpin the women's perception of police support influencing the decision to seek subsequent help. Furthermore, this attendance provides a unique opportunity to gather evidence which both substantiates the woman's claim and underpins a criminal prosecution. It is argued that the differential attitude of the police towards both the woman and domestic violence serves to further undermine the woman and negate her desire to report further domestic violence, leaving her at home with the perpetrator. In effect the first response officer acts as an advocate for the perpetrator. Although policy initiatives may increase successful recourse to prosecution, I argue that a more personal aspect of policing might influence the approach of the first response officer to policing women's experiences of domestic violence.

Finally, in chapter nine, I conclude with a summary of the main findings drawn from the two research studies presented in this thesis and identify the main contributions to new knowledge. A number of recommendations are made which highlight areas for further investigation based upon these findings.

1.5 Background

1.5.1 Subjugation: political and personal

Subjugation is not a modern phenomenon, and has been found within different societies. Smith and Masson (2000) argue that evidence has been presented of subjugation of people from ancient civilisations such as Mesoamerican cultures, and history is replete with

examples of how violent atrocities have led to the domination and subjugation of populations, including those by Ghengis Khan, the Vikings, and the more recent 'ethnic cleansing' wars involving the Khmer Rouge, Nazi Germany, and sectarian and cultural forces in Bosnia and Africa. However, subjugation does not rely on violence as the sole precursor; colonisation, cultural practices and societal influences may also form the basis of subjugation. One example of societal influence is the subjugation of women which has been a central tenet in society for hundreds of years. As such women have endured fewer rights, fewer job opportunities, and less empowerment and autonomy both within the home and in society compared to males. Since the eighteenth century women have been writing about their experiences of living within a patriarchal society, and continued to question this inequity and formulate ideas of how to redress the balance to the present day.

It can be argued that any political system could result in the subjugation of specific groups within a population being governed. Social policy has marginalised groups including the 'Dalits' people who are the lowest in the caste system of India (Govinder, 2009), the indigenous Australian population (Dixon & Scheurell, 2002), and the victims of the 'Irony of democracy' in which social politics actively subjugated black people in America (Dye & Zeigler, 2009). Gender and sexuality has also been the subject of subjugation (Hicks & Watson, 2003). However, the intention of this section of the chapter is not to present a political discussion, rather to emphasise that any political system has the capability to subjugate sections of the population it governs even if it is not the intention to do so. Subjugation may be driven by the colour of skin, social class, sexual orientation or gender. Recent cultural subjugation represents the arrogance of the western world assuming superiority over less developed countries and advocating the adoption of western cultures (Chomsky, 2003).

The slow evolution of the role women have been able to play in society has sustained this behaviour alongside the patriarchal views of society. Barrett & McIntosh (1982) argue that society has been dominated by the rights and privileges of skilled male workers, marginalising women to remain in the home and promoting the man to be the provider of financial support. Change does occur, for example contemporary society has now reinforced the notion of gender equality in the United Kingdom (UK), through the statute of the Equality Act (2011). This single anti-discrimination law was intended to eradicate differential legislation between genders, by ensuring equitable rights and protection in both the workplace and society (Home Office, 2010). Despite this Act, actual gains are not guaranteed, as men may be more highly regarded in society by occupying a powerful positional status and exerting control (Johnson, 2005). Monagan (2010) and Torrant (2011) suggest that the site of patriarchal control may be derived from societal practices of patriarchy or within the family. A common occurrence in the subjugation of women is the position of a male partner asserting a dominant role (Varghese, 2008), that Barrett and McIntosh (1982) argue may be derived from the familial environment, as it may provide an excuse for existing conditions of inequality (Torrant, 2011). Hanmer and Itzen (2000) add to this arguing that the hierarchy and structure of the family presents the medium through which men may be violent towards women, trapping women with limited recourse apart from leaving and separating the family members (Barratt & McIntosh 1982).

The subsequent sections of this chapter identify challenges for women when their subjugation is inherent within their intimate relationships, residing outside the remit of the Equality Act.##

1.5.2 Violence within the context of the family

There is a public assumption that contemporary society is more violent than previous generations, although Bowler, Turner and Orr (1996) argued that this is not necessarily true as there have been many incidents of violence throughout the centuries. Certainly violence in the family has been a factor throughout generations. Condoned under The Laws of Chastisement, Romans could physically discipline wives. Howard and Lewis (1999) and Dobash and Dobash (1979) suggest that violence within families has been well documented since the Middle Ages. The historical attitude to family violence has been to either support or condone this issue rather than its prohibition.

Whilst violence in the family predominantly affects women and children, this is not exclusively so. The National Family Violence Survey (1975) in the USA determined that men experienced violence from female partners, findings that have been substantiated (Gelles & Straus, 1999). The violence does not always occur between intimate partners within a relationship but can also occur at an inter-generational level between adults and children as well as towards the elderly. Same sex relationships and relationships within transgender people may also be complicated by the presence of violence (Poorman, Seelau, & Seelau, 2003).

The Domestic Violence and Matrimonial Proceedings Act (1976) in the UK provided some legal redress for violence within the family, particularly violence against women. Societal attitudes have changed and in current society a more proactive stance has been adopted against violence within the family. Wilkinson and Pickett (2009) argue that in unequal societies, more dominance exists with a detrimental impact on social relationships.

Blanchflower and Oswald (2004) argue that despite legislation to reduce discrimination, women's well-being continues to decline.

Violence within the family is not just a UK issue, it is a global issue. Indeed, Hausmann, Tyson and Zahidi (2008) argue that discrimination against women is entrenched and is of a global pandemic proportion. The World Health Organization (2009) identifies higher prevalence rates of family violence within societies that embrace traditional gender norms, those that ensure a lack of autonomy for women and where there are restrictive laws on divorce, suggesting that this form of violence emerges from a male dominated domain. Bell and Mattis (2000) noted the ecophenomenological perceptions of violence within the family vary, and they describe how different cultures perceive and address this violence within their societies. Within developing and industrialised countries there appear to be divergences within the sphere of family violence (Ceballo, Ramirez, Castillo, Caballero, & Lozoff, 2004) and disparities between ethnic groups (Goodwin, Gazmararian, Johnson, Gilbert, & Saltzman, 2000). Traditional gender roles serve to continue women's subordination, with men holding a superior position in relation to women (Ali, Krantz, Gul et al, 2011). Furthermore, in unequal societies, there is a higher rate of family break-down and family stress (Wilkinson and Pickett, 2009). These unequal societies may originate from organizational perceptions of gender differences (Heise, 1998). Such cultural stereotypes are engrained in both men and women, and form the foundation for the differing life circumstances that men and women face. It is clear that whilst many family groups develop equitable relationships between the family members and provide mutual control over decision making, some members within family groups retain a desire to exert power and control over another member and dominate the relationship. This is often hidden from others and shrouded in secrecy. The British Crime Survey in 2008 identified that 28% of women and 18% of men

had experienced violence by an intimate partner at some stage in their life (Home Office, 2009).

The specific theme of violence against women is well documented throughout the centuries and persists to this day. It is this gendered violence directed against women that the thesis explores. This thesis became located within a gender specific arena and focused on women's experiences of domestic violence perpetrated by a male partner. All the women participants in the narrative study reported a male intimate partner as the perpetrator of their abuse. There is limited capacity within this thesis to further discuss domestic violence within lesbian and gay men relationships, transgender relationships, or female to male violence, although Shipway (2004) argues that some studies have found these prevalence rates are similar to heterosexual relationships. This study is gender specific, involving women in a heterosexual relationship and with abuse being perpetrated by a male partner.

The disparity between men's and women's employment status in the post war era was immense and this led to a new wave of feminism in the 1960s. Stewart & Hunt (2004) state that many women felt exploited and abused, partly due to the loosening codes of sexual behaviour which expected women to be more sexually available, but without an associated increased respect for autonomy and dignity. This new wave of feminism was more extreme, powerful and radical (Rosario, 2012). Employment for women provided liberation from previously constrictive domestic lifestyles, and afforded a new perspective on the role of women; being a mother, homemaker and also employee (Whelehan, 1995). The effects of the World Wars changed society irrevocably and redefined the status and opportunities for women. The newly appointed work force created numerous new social and economic opportunities for women. Large numbers of women entered industry and the professions for

the first time. Following the Second World War a significant backlash against these working women ensued, aimed at discouraging them from working outside the home and implying that their behaviour of seeking work was damaging to themselves and the family as a whole.

By 1994 Straton (1994) suggested that feminists should acknowledge that women were also perpetrators of domestic violence. This view has challenged the traditional theoretical strand of domestic violence based on gender subjugation. The data underpinning this contrasting theory is primarily drawn from family conflict theory and uses the Conflict Tactic Scale (Straus, 1979) to measure how partners resolve relationship issues. Archer's meta-analytic review of 82 papers, found gender symmetry in perpetration rates and supported both Fiebert (1997) and Straus's (2009) view of this social development. This interesting phenomenon challenged most previous studies and has been explored in detail by Michael Kimmel (2008). He argues that contrary to gender symmetry, men are four times more likely than women to assault a partner and, further, that ninety percent of perpetrators who use violence to control and subjugate a partner are men (Kimmel 2008). The CPS (2011a) cites that 94% of defendants of violence perpetrated against women are men. Thus, the difference between acknowledging that there are some male victims of female domestic violence and claiming there is gender symmetry in the experience of these is clear. Stark (2007) argues that although the CTS measures actual violence, it disregards the context of the violence and motivational factors in understanding these acts of violence, such as coercion, domination and subjugation.

1.5.3 Feminism and domestic violence

There was minimal recourse to legal representation or societal support thirty years ago for women who were being hit by their husbands (Hanmer & Itzen, 2000; Gordon, 2002), this violence being unrecognised by society (Schechter, 1982). However with the emergence of the Women's Liberation Movement from second wave feminism in the 1970's, the rights of

women including abortion, gay rights and equality of pay became prominent (Freeman 1973). A continuation from first wave feminism, the second wave expanded the aims of feminism to include social and political reform (Whelehan, 1995). Societal support was established by Womens Aid, with the drive and vision from Erin Pizzey, as they set up the first women's refuge in 1971 in London (Refuge, 2009) to provide safety and shelter for women and children experiencing domestic violence. As women came together and shared their experiences in both the UK and USA, three significant contributions of oppression became visible: economic disparity, expected fulfilment of traditional gender roles and an unfavourable and biased criminal justice system that failed to acknowledge men's accountability of domestic violence (Liddle, 1989). With the growth of the refuge movement (particularly Women's Aid) during the 1970's and 1980's associated with increasing awareness of violence against women and movement against rape, these issues supported by the feminist movement became illuminated to the general public (Skinner, Hester & Malos, 2005). The significant increase in the public's awareness of domestic violence (Chesney-Lind, 2002) has led to the rethinking of domestic violence and recognition that it is a significant public health issue and crime (Parliamentary Select Committee 1975).

Violence against women became dipartite, with two theoretical perspectives being proposed; the family violence perspective and the feminist perspective (Kurz, 1989), as each perspective explored and identified the differences in the use of violence between men and women. Supporters of the family violence perspective (Straus, 1979, Gelles 1974) focused on conflict within the family, and explored conflict resolution within a relationship. In contrast, the feminist perspective of domestic violence focused on violence perpetrated against women by their male partners (Dobash & Dobash, 1979; Martin, 1981; Roy, 1976). Johnson (1995) highlights the disagreements between these two perspectives, identifying that they materialize from an analysis of different phenomena. The battered women's movement projected the

feminist perspective of domestic violence further into the public arena, highlighting that women were less safe in their own homes than on the streets (Haaken, 2010), with an unwillingness of the state to support women and prosecute men (Schneider, 1994). However by overlooking this crime, Schechter (1982) claims that the market economy was also negatively affected. With increasing political pressure, the criminal justice system was compelled to introduce legislation to criminalise this type of violence (Haaken, 2010).

The shifting political environment in the 1990's resulted in Governmental influences being directed towards multi-agency collaboration at a local level, although this multi-agency approach did not appear to extend to the Governmental level (Skinner, Hester & Malos, 2005). The criminality of domestic violence against women was extended to include domestic violence against children, thus involving child protection work. This necessitated the development of a new multi-agency response (Harwin, Hague & Malos, 1999). Additionally, societal myths and attitudes surrounding domestic violence were challenged by the Zero Tolerance Campaign in 1992 (McKay, 1996). This campaign argued for the inclusion of the different types of violence against women, resulting in solidarity in the unacceptability of all forms of domestic violence (Gillan & Sampson, 2000). Haaken (2010) argues that by this time, domestic violence had been acknowledged as a significant issue with evolving knowledge of the underpinning theoretical perspective of coercion and subjugation. Hanmer and Itzen (2000) highlight the development of the domestic violence forum and the progressive Government interagency and multiagency collaborations on domestic violence.

In current society, studies present evidence based on the experiences of women which captures the nature and extent of domestic violence within a relationship (Dobash & Dobash, 1992; Stanko, Crisp, Hale, & Lucraft, 1997). It is also vital to acknowledge the enormity of

the prevalence of domestic violence: the World Health Organization's (WHO) multi-country study on women's health and domestic violence against women purports that 15–71% of women have experienced physical and/or sexual violence by an intimate partner at some point in their lives (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Within the UK, recent studies suggest a 29% prevalence rate of violence against women (Hall, 2011).

The next chapter sets out to provide a description of the structure and rationale for this thesis.

Chapter Two: Literature Review

2.1 Introduction

This chapter presents a review of the literature surrounding issues of domestic violence. The primary purpose of the literature review was to shape the research project and formulate the problem (Blaikie, 2007). The collected literature has been categorised into relevant sections of the chapter to present a coherent and logical flow of information (Crookes & Davies, 2006). Domestic violence literature extends far beyond the boundaries of any one discipline; it is vast and varied, and thus the sources for this literature review extend through several disciplines including sociology, psychology, criminology, anthropology and women's studies. The principal literature search was conducted on several data bases including Cumulative Index of Nursing and Allied Health Literature, Cochrane Library, CSA Illumunia, PubMed, National Library for Health, Psychinfo, BIDS IBSS, Blackwell Synergy, Science Direct and Ingenta. Whilst it is acknowledged that the literature presented is far from exhaustive, I have striven to present a comprehensive review of the literature relevant to, and informing the research studies presented within, this thesis.

2.2 Context of violence against women by an intimate partner

2.2.1 Prevalence and risk

The World Health Organization (WHO) has raised the issue of violence over many years, defining this as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community, that either

> results in or has a high likelihood of resulting injury, death, psychological harm, maldevelopment or deprivation (Krug, 2002:5).

This generic definition defines interpersonal and intercultural violence. However, when we seek to define gender based violence the United Nations (UN) Declaration on the Elimination of Violence (1994) defines this specific violence against women as:

> Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (Declaration No: A/RES/48/104).

It is significant that violence against women is so prolific that it warrants a specific definition. Globally, approximately one in three women have been physically assaulted, abused or coerced into sex at some stage in their life, by a known perpetrator in the majority of incidents (United Nations Human Rights, 2011). Acknowledging this, the United Nations General Assembly designated 25th November as the annual International Day for the Elimination of Violence against Women (WHO, 2011).

Domestic violence appears to be increasing on a global scale, being identified by the WHO as a problem of pandemic proportions (2011). Strong commonalities shared by women across the globe, in terms of their experiences of domestic violence, regardless of the country of residence, cultural or socio-economic background have also been identified (World Health Organisation, 2005), with high prevalence rates (Bacchus, Mezey, & Bewley, 2004; Basile, 2002; Bradley, Smith, Long, & O'Dowd, 2002). For an individual to be at risk of

experiencing domestic violence, the single most important risk factor is being a woman (Lovendski & Randall, 1993).

In the USA a study involving 12 major cities identified that 9.8% of women had experienced abuse within the previous two years (Walton-Moss, Manganello, Frye, & Campbell, 2005). The British Crime Survey (BCS) 2009-2010 identified that in the UK, 29% of women had experienced some form of domestic violence during their lifetime (Hall, 2011), whilst Feder et al (2009) identified rates of between 13 to 31%. The effects of domestic violence have significant cost implications for health care. Walby (2004) estimated this annual cost within the UK as being in excess of £1.2 billion, i.e. 3% of the total NHS budget.

Nicholas, Povey, Walker, and Kershaw (2005) argue that victims of domestic violence may feel more willing to disclose their experiences using a non-personal approach; the BCS therefore collects data regarding domestic violence via a self-completion module which then provides a more complete synopsis of domestic violence (Mirrlees-Black, 1999; Walby & Allen, 2004). Table 1 provides a synopsis of the range of the lifetime prevalence rates of domestic violence in the female population.

Table 1: Lifetime prevalence rates of domestic violence in female population

Author(s)	Year	Prevalence rate of domestic violence (%)	Sample size	Location	Methodology
Hamberger, Saunders & Hovey	1992	38.8%	394	USA	HITS Questionnaire
Keeling & Birch	2004	26.3	332	UK	Survey/AAS
Keeling, Burch & Green	2004	35.1	302	UK	Survey/AAS
Walton-Moss, Manganello, Frye, & Campbell	2005	9.8	3637	USA	Survey/CTS
Garcia-Moreno, Jansen, Ellsberg, Heise & Watts	2006	15-71	24097	Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania	Interview
Hall	2009-2010	29		UK	Survey/BCS Interview
Feder et al.	2009	13 to 31		UK	Systematic Review

Domestic violence permeates socio-economic boundaries, communities (Home Office, 2011b) cultural, racial and class distinctions (Kaur & Garg, 2008; Bell and Mattis, 2000). However, Sokoloff and Dupont (2005) highlight the increasing awareness of disparities in the nature of the physical violence between cultural groups (Goodwin, et al., 2000), as definitions of this violence diverge between cultures (Yoshihama, 1999; Ceballo, et al., 2004). Yoshihama, (1999) argues that the definition of domestic violence may be influenced by the socio economic environment, with some acts being perceived as violent in some cultures, whilst not in others. This illuminates a latent inadequacy of domestic violence terms, and the potential need to develop specific forms of identification particular to women's cultural background (Indu, Remadevi & Vidhukumar et al., 2011).

A moral relativism is apparent within cultural explanations of domestic violence (Sokoloff and Dupont, 2005) as both honour killings and patriarchy are cited in domestic violence murders (Chesler, 2009; Haaken, 2010). Whilst Chesler (2009) argues that these killings differ as the former revolves around the safeguarding of the family honour rather than the personalisation of domestic violence, Goulding and Duggal (2011: 13) define this crime as: 'physical or psychological violence committed in the name of 'honour' predominantly against women…'.

2.3 Intentionality

Despite literature exploring the tactical behaviours of perpetrators as they attempt to engage a woman into a relationship, there appears to be limited evidence surrounding the early (pre-violence) relational process of abusive relationships (Olsen, 2004). The literature alludes to how women become emotionally involved in a relationship with a violent man and then embroiled within a cycle of violence. Exploring the early development of a relationship in which a man engages a woman with the intention of exerting abuse (including physical violence and controlling behaviours to entrap her), Dutton & Goodman (2005) argue that perpetrators use behaviours to 'soften' a woman, or to 'set the scene' for impending abuse. Craven, Brown, & Gilchrist (2006) refer to this as 'grooming'. The key element of a relationship in which domestic violence features is the range of controlling and coercive behaviours directed by the perpetrator onto the partner, thereby limiting the partner's autonomy and undermining her self-confidence (Harne & Radford, 2008). To understand these behaviours it is necessary for them to be constructed as coercive control, with the range of behaviours constituting domestic violence being viewed as points on a continuum (Stark, 2007). It is critically important to understand the impact of coercive control on the liberty, autonomy and self-confidence of women in a violent intimate relationship as these are the

central elements to a relationship in which domestic violence features. It is this theory of power having originated from a patriarchal society that I use as an explanatory framework and theoretical basis of the analysis (see chapters five to eight inclusive), referring to Raven's (1992) elaboration on the theory of social power (French & Raven, 1959). This theory is valuable as it views power as dynamic and distinguishes five discrete bases of power: coercive base of power, used to force someone to do something against their will; legitimate power, of investing in a role such as a partner and then using that as a legitimate reason for a certain behaviour; referent power, afforded to a person due to affection; expert power, as an expert or someone very knowledgeable; and reward power, being the ability to give another person what they want but on the premise of a return favour (French & Raven, 1960)

Domestic violence defined within the concept of 'control' provided the theoretical foundations for the development of the Domestic Abuse Intervention Project (1984) (DAIP) in Duluth, Minnesota in 1980. The Duluth Power and Control Wheel (Figure 1) originated from women's experiences of domestic violence perpetrated by men and represent the most common experiences.

Figure 1: Duluth Power and Control Wheel (Pence and Paymar, 1993a)

The development of the Duluth Wheel (Pence & Paymar, 1993a) has been used to define and clarify the behaviours of perpetrators who seek to coerce, subjugate and assault their intimate partners. The Power and Control Wheel describes a number of interrelated control tactics that Stark (2007) has subsumed under four headings: violence, intimidation, isolation and control. Schneider (2000) refers to these four tactics as the 'generality' of coercive control, whilst Stark (2007, 2009) considers the coercive control as the dominant strategy used to subjugate women in intimate relationships. Pence and Paymar (1993b) emphasise that although

domestic violence has several forms, it is the physical and sexual violence or credible threat of this violence that provides the milieu in which to develop the other forms of domestic violence.

Coercive power (Raven, 1992) is based on the woman's belief that she will experience negative, often debilitating and destructive consequences if she does not comply with the perpetrator's demands. Through the exercise of coercive power the perpetrator of domestic violence creates the expectancy of negative consequences. This expectancy results in the self-regulation of a woman's behaviour based on the belief that she is being watched by her abusive partner or his companions. Literature on stalking highlights the confusing and disconcerting nature of these paradoxical feelings (Logan, Cole, Shannon, & Walker, 2006).

The growing emotional dependence of the woman is associated with the manipulation exerted by her partner to further control her. Indeed, by living with the woman he is able to potentially micromanage her day to day life, thereby limiting both her autonomy and association with others (Harne & Radford, 2008) whilst enforcing obedience and conformity. Dutton and Goodman (2005) suggest that when the emotional dependence in the relationship is unbalanced and extreme, the person who is less attached to the relationship has the greater power.

2.4 Statutory responses to domestic violence

Historically, criminology has failed to recognise the masculinity of crime, particularly violence against women (Tomsen, 2008). An insufficiency in challenging men's violence with legal redress has led to this violence being prevalent within a patriarchal structured relationship between men and women (Stanko, 1995) one that Radford and Russell (1992)

argue have facilitated a male climate of misogyny. Miedzian (1992) highlights the masculine mystique, behaviours of men such as violence, uncaring attitudes to sex and a need to be dominant, with a glorification of war and violence as a normal paradigm of manhood. Hayward (1999) argues towards a new concept of masculinity with men taking a proactive stance in working towards addressing violence against women. The deconstructionist approach of feminists contributed to understanding how the legal system constructed sexual difference both in the appointment of men in the major legal positions in the courts and in the policing of this crime. Following the passing of the Domestic Abuse, Crime and Victims Act (2004), the coalition between the statutory agencies and voluntary agencies is facilitated within the newly developed Multi Agency Risk Assessment Conference (MARAC) and the role of the Independent Domestic Violence Advisers (IDVA). Thus, operationally there is an overlap of each statutory agency's remit, theoretically taking the necessary multi-disciplinary approach to supporting women following domestic violence.

2.4.1 The role of the law enforcement agency

Historically, the police response towards domestic violence has been to regard this as a private problem to be resolved within the family, thereby categorising it as a non-criminal issue (Tong, 1995). However, both societal and criminal justice system attitudes to domestic violence have been challenged in recent years. The Crown Prosecution Service (CPS) (2005) has acknowledged the severity of domestic violence and the necessity to improve police and agency responses, taking responsibility for prosecuting domestic violence cases since 2005. Consequently, a pragmatic endorsement of legislation within the UK has served to bring perpetrators to justice whilst ensuring the victim is located at the focal point within the criminal justice system (Robinson, 2006). Modern policing does not solely rely on the activity of the law enforcement agency; rather, as argued by Richards, Letchford and Stratton

(2008: 5), it can be contextualised as 'the output of a variety of agencies with multiple objectives and lines of accountability'.

The importance of maintaining the autonomy of the woman following domestic violence is highlighted by the current system of law enforcement in North America. Mandatory arrests and prosecutions of perpetrators of domestic violence in America and Canada has brought about unintended consequences; many victims are reluctant to call the authorities for help (van Wormer & Roberts, 2009). Tapley (2010) posits that in the UK, following police involvement in domestic violence incidents, there are examples of mothers feeling they are being punished for their partner's behaviours. Thus on both sides of the Atlantic there is a need for reforming the current policing of domestic violence.

After making a statement following an incident involving domestic violence, women may choose to retract it, this being one of several reasons for the high attrition rates of domestic violence prosecutions. The CPS cite the victim wanting no further action as the other major contributing factor to attrition rates (Her Majesty's Crown Prosecution Service Inspectorate, 2004), and it has recently launched a public consultation to address this issue (CPS, 2011b). Other influences include fear of retaliation by the perpetrator, lack of financial resources or wanting to maintain the relationship in some form (Gill, 2004). Robinson and Cook (2006) identify that policy initiatives have been integral to enhancing the support offered to women disclosing domestic violence and to increasing the number of women deciding to continue with their cases instead of retracting their statements.

Harne and Radford (2008) argue that the decision surrounding retraction may also be affected by police practice. The recording of a statement is reliant on attending officers recognising and acknowledging the domestic violence incident as a crime. They may use their discretion

based on individual ideologies or judgments about the perpetrator, leading to the arrest of both the perpetrator and the female victim (Ferraro, 1989). The National Policing Improvement Agency (NPIA) (Association of Chief Police Officers, 2004), on behalf of the Association of Chief Police Officers, has issued clear guidance on the 'Duty of Positive Action'. Underpinned by the Human Rights Act (1998), this guidance aims to provide adequate protection for victims of domestic violence. High rates of attrition may be diminished through provision of effective and ongoing support which reduces anxieties arising from interaction with the criminal justice process (Hester & Westmarland, 2005). The most recent British Crime Survey of 2009-2010 (Hall, 2011) reported that 29% of women had experienced a form of domestic violence, which equates to approximately 4.8 million victims. A UK study by Hester and Westmarland (2005) revealed that in three quarters of incidents of domestic violence which actually led to an arrest, less than a third led to a criminal conviction. The CPS data demonstrates that 31% of prosecutions during 2007/8 resulted in unsuccessful outcomes (CPS, 2009a) and 28.1% during 2008/9 (CPS, 2009a), although not all are attributable to victim retraction.

The Domestic Violence, Crime and Victims Act (2004) affords police officers increased autonomy in dealing with perpetrators of domestic violence in conjunction with maintaining the safety of the victim. Additionally, the Home Office (2009) advocates the use of restraining orders to protect victims from harassment, even if the perpetrator has been exonerated. Guidelines in the UK recommend that perpetrators and victims of domestic violence are seen independently of each other to ensure confidentiality is maintained (CPS, 2009a). This approach additionally affords the victim time for a needs assessment (obtained by the use of CAADA-DASH (Co-ordinated Action Against Domestic Abuse, 2009) or MERIT (McKenna, 2010) form (see section 2.4), and to gather evidence. It is apparent that

support ‘as well as being important to the victims and witnesses, ... helps to ensure that they stay engaged, thereby assisting the investigation and building the strongest possible case against the offender’ (Audit Commission, 2003: 29). The trajectory of successful domestic violence prosecutions has continued to increase from 2008 to 2011 (see table 2). A change in policy for recording domestic violence in 2008 had resulted in domestic violence being recorded as part of the VAW strategy, rather than a hate crime (CPS, 2010a). This amendment acknowledges the assertion that the majority of defendants of domestic violence (93%) are men (CPS, 2010b).

Table 2: Domestic Violence attrition rates and points of attrition in the UK

Date	Unsuccessful prosecutions due to victim issues (%)	Number of prosecutions (number)	Unsuccessful prosecutions (%)	Successful prosecutions (%)	Author(s)
2006-7	15%	53%	35%	60%	CPS (2011)
2007-8	14%	64%	31%	69%	CPS (2008)
2008-9	12%	63%	28%	72%	CPS (2009)
2009-10	13%	63%	28%	72%	CPS (2011)
2010-11	Unknown	95,257	Unknown	72%	CPS (2011)

2.4.2 The role of the social worker

The role of the social worker is a complex one incorporating the provision of support to families, safeguarding members of society and being able to work collaboratively with the police force (Humphris & Hean, 2004). However, this combined working has been identified as inconsistent, resulting in poor recognition of those in need of social worker intervention (Stanley, Miller, Richardson-Foster, & Thomson, 2009). The paramount ethical principle of social work has been cited as being respect for people (Plant, 1970); the quest for social justice (Gray, 1995); or an amalgam of the two (Clark & Asquith, 1985). Based on a relationship of truth and equality, fulfilling the social worker’s role should result in adequate

support for subjugated women who experience domestic violence. However, Orme (2002) argues that women may experience unfair treatment from social workers compounded by the lack of attention to the ethics of care within social work (Banks, 1995). Fox (1995) argues that one of these ethical principles, the essence of care, may be altruistic or narcissistic, both of which could be perceived as being controlling in nature. The close surveillance associated with care provision in terms of watching the women may be considered as a form of subtle power (Raven, 1992) as social workers often rely on observation in supporting women experiencing domestic violence.

Some authors have argued for consistency of feminism within social work (Greene, 2008; Saulnier, 1996; Valentich & Gripton, 1985). Greene (2008) expands this argument and identifies that social workers who draw on a feminist perspective seek to understand the woman's experience from her own standpoint, rather than interpreting her talk within a clinical constraint. The Strengths Model is used in social work to help women find their own way and to carve out their own paths in their process of recovery (Rapp & Goscha, 2006). Lord Laming, in his report on child protection, recommended that 'referral processes should include automatic referral where domestic violence, or drug or alcohol misuse, may put a child at risk of abuse or neglect' (Department of Health, 2010c: 10), so that the social worker fulfils their statutory responsibilities on safeguarding. This, then, will impact on the Strengths Model and the woman's autonomy.

According to the recent Department of Health document 'Building a safe and confident future: Implementing the recommendations of the Social Work Task Force' (Department of Health, 2010a), social workers should work with women and their families seeking to provide individualised care dependent upon their needs. Social workers are an integral provider in the

statutory support offered to women experiencing domestic violence. Davis and Lockhart (2010) identify that:

> A cornerstone of professional practice in both professional social work and the domestic violence field is the concept of empowerment practice. Within the domestic violence field, empowerment practice is addressed first as a strategy to assist individual women to take control of their lives and second, as a strategy for taking action against domestic violence in certain communities (pg xxvi).

In the UK, the 'Shaping Our Lives' document clearly identifies the personal attributes required for social workers to make a meaningful contribution to their profession and clients:

> They place a particular value on social work's social approach, the social work relationship and the positive personal qualities they associate with social workers. The latter include warmth, respect, being non-judgemental, listening, treating people with equality, being trustworthy, openness and honesty, reliability and communicating well (Beresford, 2007: 4-5).

Endorsed by the British Association of Social Workers (2011), these key attributes are further defined and referred to in the Code of Ethics, subsumed under the headings of human dignity and worth, social justice, service, integrity and competence. The General Social Care Council (2010a), which regulates the social work profession, ensures adherence to these codes of expected behaviours whilst setting the standards of practice and conduct.

Extending this strategy it is apparent that social worker practice lies within a dichotomous paradox, of empowering women to protect their child from harm whilst simultaneously

integrating a legal framework and local procedures as mandated in the Every Child Matters: Change for Children document (Department for children schools and families, 2009) to *ensure* the safeguarding of children. This latter strategy may negate a mother's actions to protect her child if they are considered ineffective and leave the child at risk of harm (Patton, 2002).

Yet, despite the defined attributes of social workers, there appears to be a significant lack of cognisance of the dynamics of domestic violence within the social work profession. Stanley et al (2009) highlighted that the practice of sending letters to the homes of families following domestic violence in conjunction with a lack of further communication should be re-considered; one has to consider the impact of this letter on the perpetrator's behaviour. Stanley et al (2009) also argue that families experiencing domestic violence who are not involved with social services, require interventions to be made available from other statutory agencies including the health service.

2.4.3 Statutory responsibilities of the health service

The Royal College of Obstetricians and Gynaecologists (2001), the Royal College of Midwives (1999) and the Department of Health (DH, 2010b), have all advocated the inclusion of education and training for all professionals working in the health care arena, and the routine investigation for domestic violence. Health professionals should have an identified system, which is both compassionate and effective, to support women experiencing domestic violence (Friend, 1998). However, Davison (1997) identified that the personal experiences of violence within the context of an intimate relationship will have a direct effect on the health professional's capability of making a clinical decision. Additionally, Mezey et al (2004) argue that health care professionals do not want to ask about domestic violence due

to lack of awareness; moreover, Walby and Myhill (2004) suggest that women are more likely than men to experience negative responses to health complaints. Thus it appears that the responses afforded to victims of domestic violence by the health service serve to ensure it remains a private issue (Stark, et al., 1979). Only a minority of survivors of domestic violence are identified by health professionals (Feder, Hutson, Ramsay, & Taket, 2006). Indeed, fears surrounding confidentiality and lack of protection if the perpetrator becomes aware of the revelation are significant barriers to disclosure (Harne & Radford, 2008). Recommendation No.9 of the recent Department of Health (DH) document 'Responding to violence against women and children – the role of the NHS' advocates that 'women and children disclosing violence or abuse should feel assured that their information will be treated appropriately' (DH, 2010c: 6). Additionally, the report of the Taskforce on the Health Aspects of Violence Against Women and Children' by the Department of Health (DH, 2010b) now provides health care professionals with a strategic plan in supporting women and children who experience domestic violence. The significance of a plan is further emphasised in a recent DH publication:

> A number of the women and girls who were themselves victims of violence expressed the view that the NHS was one of the key agencies to which they either hoped they could turn to or had already turned to for help or support. Not all received the response they hoped for and many felt let down by healthcare professionals individually or by the system (Department of Health, 2010b: 3).

The Department of Health (2007) argue that 30% of domestic violence starts in pregnancy. This violence then poses a significant threat to the health and wellbeing of both the woman and her unborn child. The Royal College of Midwives' 'Position paper' advocates

recognition of domestic violence, documentation of it, and giving women information to make their own choice (Royal College of Midwives, 1999). However, Aston (2004) argues that midwives usually do not raise the subject of domestic violence, leaving women to take the lead in initiating discussion about it with their midwife. This lack of communication between the woman and the midwife may revolve around the midwives' own personal experiences of domestic violence (Mezey, et al., 2004).

Currently, the DH (2010a) is developing strategies to improve the efficacy of support offered to women and girls experiencing domestic violence. These include the Family Nurse Partnership programme (Barnes et al., 2008) and Improving Health, Supporting Justice (DH, 2009), the latter crossing both the health service and criminal justice system, recognising that the effects of domestic violence interweave within all statutory agencies. Despite a statutory agency collaborative response to domestic violence being advocated by the DH (Chang et al., 2005), it becomes apparent when reading the literature that this is notional. Furthermore, the nexus of this remit for partnership working appears to lie within the domain of children's services provision, not extending to the services for adults. Despite the knowledge that 'partnership approaches are largely built on the premise that no single agency can deal with, or be responsible for dealing with, complex community safety and crime problems' (Berry, Briggs, Erol, & Staden, 2011: 1), there appears to be a paucity of evidence that this approach towards domestic violence within the context of an intimate relationship can be substantiated**.**

2.5 Impact of violence

In order to understand the impact of domestic violence on a woman it is necessary to explore these actions through a holistic perspective. There is literature available to us that substantiates the claim that domestic violence negatively affects the biopsychosocial aspects

of a woman's life (O'Campo et al., 2006; Stanko, et al., 1997). This section of the chapter presents what is known about these effects and explores the health sequelae to domestic violence. The many aspects of domestic violence include physical, sexual, emotional and economic abuse (Walby, 2004). Women may experience some of these forms of domestic violence, or all of them, dependent upon their relationship. It is widely recognised that the effects of these forms of abuse pervade all aspects of daily living (Dienemann et al., 2000). The effects of domestic violence and the longevity of its effects are detrimental to the health and wellbeing of the survivor (DH, 2005).

The physical impact of domestic violence may result in serious physical harm, injuries or even death. There are a multitude of physical symptoms that suggest that the woman is being abused and many injuries that necessitate medical treatment. These include burns which may lead to permanent disfigurement, bites, wounds inflicted by an implement such as a knife, fractures of the jaw and other bones, and joint and internal injuries (Stanko, et al., 1997). Furthermore, in societies where access to firearms is widespread it is not surprising that these weapons are often used by the perpetrator of domestic violence, and that these communities have higher rates of murder (Bailey et al., 1997).

There are many descriptions in the literature of the serious injuries resulting from domestic violence that may also result in a significant disability (Beck, Freitag, & Singer, 1996). Physical injury when inflicted by an intimate partner is often associated with other types of domestic violence, which this chapter will now explore.

The literature is replete with references to male coercive control regulating women's fertility and pregnancy (Campbell, Woods, Choauf, & Parker, 2000; Moore, Frohwirth, & Miller,

2010). However, this coercion extends beyond the boundaries of controlling a woman's gestational occurrences. It permeates through all aspects of her sexuality and may result in sexual abuse and violence, enforced prostitution and rape (Watts & Zimmerman, 2002). The prevalence rates of rape related to domestic violence have been estimated at between 14 % of married (and previously married) women raped by (ex)/husband, and 29.3% of rape by an intimate partner in women experiencing depression (Dienemann et al. 2000). Furthermore, women in such relationships are also at risk of sexually transmitted diseases due to risk taking in the sexual behaviours of their violent partners (Raj et al., 2002).

Women tend to view rape as a sexual assault by a stranger rather than assault by a partner, so the prevalence rates of sexual violence by an intimate partner are dependent upon women's perceptions of rape (Whatley, 1993). The Stern Report (2010:7) highlights the illegality of rape, citing a lawyer as stating 'Rape is unique as it is an inherently lawful activity made illegal because of lack of consent'. Rape that leads to marriage is tolerated and occurs in many cultures (Human Rights Watch, 2001). Despite its criminality, rape remains difficult to detect or prove when perpetrated by an intimate partner. This is further complicated as women may not conceptualise the experience as rape, even though the event itself may meet the legal requirements for such a classification (Friend, 1998). Additionally, statutory agencies may fail to take action. A recent Supreme Court case in the UK (Hill, 2012), illuminates the difficulties faced by women who are raped by their male partners, and are subsequently pressurised to retract their statement. Rape, particularly marital rape, continues to be under reported and unlikely to result in prosecution, and thus the experience becomes invalidated. Bergen & Bukovec (2006) reported that over half of the men in an abusive relationship had sexually assaulted their partners.

Unwanted or unplanned pregnancies pose a three fold increase in the risk of physical violence over a planned pregnancy (Goodwin, et al., 2000; Pallitto & O'Campo, 2005). The CPS, (2011b) has recently launched a consultation document to further explore these issues. They highlight the need for the legal system to be supportive of women experiencing rape within domestic violence, and to meet their needs following retraction of a statement.

Psychological abuse within the context of domestic violence is perhaps one of the most difficult areas to both prove and prosecute due to a lack of a common definition. The emphasis appears to be on recognition of behaviours that constitute this type of abuse, clearly defined by the Duluth Model (Pence & Paymar, 1993a). O'Leary (1999) argues that amongst policy makers and researchers, there is an implicit assumption that the sequalae to physical abuse overrides the experiences of psychological abuse. However, Mullender's (1996) work highlights the nature of psychological abuse, and further, that it is often accompanied by physical and sexual violence which reinforces the perpetrator's control over the woman.

Mental health sequalae to domestic violence include anxiety, depression and post traumatic stress disorder (Bonami et al., 2006), often presenting as co-morbidities such as self-harm, and drug and alcohol misuse (Kaysen et al., 2007; Mrazek & Haggerty, 1994). Additionally, women may experience low self-esteem, anxiety and depression, passivity and learned helplessness (Stewart & Cucutti, 1993), as well as post traumatic stress disorder and suicidal feelings (British Medical Association, 1998). The significant annual costs associated with treating mental disorders due to domestic violence has been estimated at £176 million (Walby, 2004).

The association between alcohol and women experiencing domestic violence has been well established (Kaysen, et al., 2007; Klostermann & False-Stewart, 2006; Lipsky, Caetano, Field, & Larkin, 2005; Testa, 2004). Although alcohol itself is not a causative factor for domestic violence, an alcohol dependency increases the risk of the occurrence of this violence (Jewkes, 2002). There appears to be co-occurrence of drug misuse and domestic violence in new relationships (Testa, Livingston, & Leonard, 2003).

Historically, pregnancy has been depicted as a unique life event for a woman, an embodiment of femininity, and the gestational period could change the woman's lifestyle in preparation for the birth (Stewart & Cecutti, 1993). Early theorists described this stage as an 'antenatal symbiosis' (Guntrip, 1968) whereby the pregnant woman is expected to demonstrate physical and emotional altruism (Pollock & Percy, 1999). Indeed, pregnancy is a period of immense psychological and physical change that impacts on the woman and her family.

The creation of new life and its inclusion within a relationship often changes the dynamics, which might result in a detrimental effect upon the relationship. According to DH (2007) approximately 30% of domestic violence commences during pregnancy. This is supported by The Royal College of Obstetricians and Gynaecologists (2001). This violence then poses a significant threat to the health and wellbeing of both the woman and her unborn child, and might adversely affect the outcome of the pregnancy with an increased risk of significant morbidity or death (El-Kady, Gilbert, Xing, & Smith, 2005). For women in their first pregnancy, when planned, a cessation in domestic violence may occur (Jasinski, 2001). However, if the woman becomes pregnant sooner than the partner intended, or if the partner did not want the baby, then the woman is over twice as likely to experience domestic violence (Gazmararian et al., 1996; Goodwin, et al., 2000). Of pregnant women who died in

the United Kingdom between 2003 and 2005, 14% had self-reported experiencing domestic violence (Lewis, 2007).

Perinatal domestic violence refers to any violence occurring before, during and after pregnancy (up to one year after childbirth) committed by an intimate partner (Sharps, Laughon, & Giangrande, 2007). During this period the violence may commence or worsen (Garcia-Moreno, et al., 2006), with some studies suggesting prevalence of between 6 and 21% in pregnancy and between 13 and 21% prevalence in the post partum period (Campbell, et al., 2000). Moreover, a synthesis of results from 13 studies found prevalence rates of domestic violence in pregnancy ranging between 0.9% (Sampselle, Peterson, Murtland, & Oakley, 1992) and 20.1% (Gazmararian, et al., 1996). These significant disparities in disclosure rates have been attributed to differences in research methodologies and samples (Jasinski, 2004). Data from the Centres for Disease Control and Prevention's (1999) PRAMS 1996 Surveillance Report (Ahluwalia, Colley-Gilbert, Fischer, Rogers, & Whitehead, 1996) identified that domestic violence rates in pregnancy were much lower in the United States population based data than those revealed in studies using a hospital based sample (Jasinski, 2004). Rates of domestic violence associated with pregnancy appear to be affected by whether the population being sampled is community based or hospital based, and also by the assessment tools that are used (Jasinski, 2004). Probability samples for the female population of childbearing age, regardless of their pregnancy status, have identified prevalence rates of between 15% (Gelles, 1990) and 20.5% (Jasinski, 2001), suggesting that disclosure rates remain similar through the lifetime of women.

During pregnancy domestic violence has been reported as being a specific risk factor, with nine identified adverse outcomes reported, six of which were associated with domestic

violence only during pregnancy. These six were pre term labour, vaginal bleeding, severe nausea, severe vomiting, dehydration and urinary tract infections (Sharps, et al., 2007). In a study by Rodríguez et al (2010) of the women who had experienced domestic violence in the antenatal period, almost half (45.7%) were depressed. Additionally, antenatal complications have been identified such as poor maternal weight gain, anaemia, and bleeding in the first or second trimesters (Parker, et al., 1994). The overall miscarriage rate is reported as 15-20%, of which the vast majority (80%) occur within the first trimester of pregnancy (Puscheck, 2010). Although usually due to a plethora of natural causes, this may also have resulted following domestic violence.

Depression during pregnancy is associated with several morbidity factors including increased substance abuse, poor nutritional condition of the mother, decreased fetal growth, premature delivery, postnatal depression and also suicide (Martin et al., 2006). Higher rates of depression in pregnant women who have experienced domestic violence have been identified in several studies (Amaro, Fies, Cabral, & Zucherman, 1990; Campbell, Poland, & Waller, 1992). Depression in mothers impacts on their parenting skills, with higher levels of shouting, spanking and feeling annoyed with their children being demonstrated (Lyon-Ruth, Wolfe, & Lyubchik, 2000).

The birth of a baby may lead to a rise in tensions within a relationship in which domestic violence features, especially if the woman does not comply with the perpetrator's demands for sex immediately after childbirth (Dutton & Goodman, 2005). Additionally, there appears to be a correlation between rapid repeat pregnancies (repeated pregnancy completions up to twenty four months apart) and experiences of domestic violence (Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999).

In the postnatal period, breastfeeding problems have been associated with domestic violence (Jasinski, 2004). Bowen et al (2005) argue that women who experience adversity in the antenatal period are at higher risk of experiencing domestic violence after the delivery of their baby. Significant prevalence rates (35.6 %) of domestic violence in the postnatal period have been cited (Vivilaki et al., 2010), warranting this as a substantial concern for women and newborn babies. These rates are mirrored in the studies involving women in the antenatal period (Bacchus, et al., 2004; Keeling, Birch, & Green, 2004). Mezey et al (2004) have identified a lack of any significant difference between antenatal and postnatal women in the reporting of domestic violence, and table 3 presents the range of these prevalence rates.

Due to the direct physical assaults in pregnancy, which are often directed at the women's enlarging abdomen (Bacchus, et al., 2004), the risk to the health of the fetus becomes considerable. Premature birth or fetal death are associated with exposure to domestic violence (El-Kady, et al., 2005).

In association with the physical assaults, the teratogenic effects of substance misuse, smoking and alcohol further cause assaults on the developing fetus. Indeed many research studies suggest that in order to cope with living in an abusive relationship, many women use a combination of these as a coping strategy (McFarlane, Parker, & Soeken, 1996b). These unhealthy behaviours are known to have an adverse effect on the birth weight of the baby. However, some research has found that women who experience domestic violence in pregnancy, may have lower birth weight babies regardless of lifestyle, when compared to non-abused women (Bullock & McFarlane, 1989; Campbell, et al., 1999). Analysis of data from PRAMS demonstrates a small but significant relationship between domestic violence in

pregnancy and low birth weight babies, even when accounting for smoking, age and education (Silverman, Decker, Reed, & Raj, 2006).

Table 3: Prevalence rates of domestic violence in pregnancy and postpartum

Authors	Date of publication	Stage of pregnancy	Prevalence rate of dv (%)	Location	Method
Sampselle, Peterson, Murtland & Oakley	1992	Antenatal	0.9	USA	Survey
Gazmararian et al.	1996	Antenatal	20.1	USA	Survey
Campbell et al.	2000	Antenatal	6-21	USA	Survey
Keeling, Birch, & Green,	2004	First trimester	19.5	UK	Survey
Bacchus, Mezey, Bewley	2004	35 weeks gestation	5.8	UK	Survey
Keeling & Birch	2004	First trimester	8.5	UK	Survey
Lewis	2007	Antenatal	14	UK	Reporting of maternal deaths
Campbell et al.	2000	Postpartum	13-21	USA	Survey
Bacchus, Mezey & Bewley	2004	0-10 days postpartum	5	UK	Survey
Vivilaki et al.	2010	0-12 weeks Postpartum	35.6	Greece	WAST Survey
Keeling & Mason	2011	0-5 days postpartum	5.8	UK	Survey

2.6 Disclosure issues

Disclosing domestic violence at any stage of a woman's life appears to be complex, and dependent upon personal, organisational and professional factors. The literature offers explanations of many of the factors that affect disclosure. Livesey (2002a) in her work on disclosure of childhood experiences of sexual abuse argues that, despite the verbal act of disclosure being a simple process, the actual act of speaking the words is far more complex. Indeed, it is evident that when considering disclosure, a multitude of factors intersperse within a woman's emotions, thus making the enquiry about domestic violence more challenging. The Home Office (2009) in the UK advocates that those in public services ought to play a more significant role in identifying early signs of violence and providing better support for its victims. The willingness to disclose domestic violence varies considerably and has been identified as being adversely affected by lengthy interviews non-specific to domestic violence, the technique of the interviewer and inadequate ethicality of the research project (Ellsberg & Heise, 2002). Fear of retaliation, embarrassment, guilt and failure may all act as a deterrent to disclosure and ultimately leaving the abusive partner (Davison, 1997; Walker, 1990).

To encourage women to disclose domestic violence when accessing the health care system during the pregnancy/childbirth continuum, a conducive environment is necessary. Research has suggested that women are more likely to disclose to their family doctor in primary health care rather than Accident and Emergency Departments (McKie, Fennell, & Mildorf, 2002); but Plitcha & Falik (2001) argue that fear of a doctor's reactions to their disclosure or a rejection of their experiences also contribute to refraining from disclosing domestic violence. Furthermore, Harne and Radford (2008) argue that fears surrounding confidentiality and lack of protection if the perpetrator becomes aware of the revelation are also significant barriers to

disclosure. Whilst these are to be considered, it is evident that there is a further wealth of contributing evidence affecting disclosure of domestic violence within clinical practice. These suppositions include the provision of a safe and confidential arena, being non-judgmental and caring (Battaglia, Finley, & Liebschutz, 2003), and a perceived rush to be seen/treated (Hathaway, Willis, & Zimmer, 2002). Furthermore, intrinsic factors may include feelings of failure, guilt, shame and embarrassment (Bauer, Rodriguez, Quiroga, & YG, 2000). Burton (1996) argues that self-blame may prevent a woman from seeking help. The social consequences of disclosing domestic violence may result in women losing custodial rights of their children (Stanley, 1997). Perpetrators may threaten mothers with this knowledge, an element of the coercive behaviours often manifested within an abusive relationship (Harne & Radford, 2008). However, Uttal (2009) argues that some mothers remain due to family ideology, others stay due to fear of involvement by child protection agencies (Davies & Ducket, 2008). Focusing on the women's wishes to disclose, Chang et al (2005) argue that individualised interventions that ensure privacy and provide safety and autonomy are required and, further, that these allow for each woman's readiness to access help and support.

The Department of Health's (2010b) recommendations for addressing domestic violence in pregnancy have been recently published, but fall short of recommending a routine screening process. According to Taket et al (2003), the repetitive questioning about domestic violence may increase disclosure rates as cognitive restructuring is enhanced by repeated narrative construction (Holmes et al., 2007), whilst Pennebaker, Mayne and Francis (1997) adds to this by stating this will then have a positive impact on a woman's physical health through disclosure. Rodriguez et al (2006) argues that the majority of women will disclose when asked about domestic violence, whilst an absence of a strategic screening programme for

women has a negative effect on disclosure (Shadigian & Bauer, 2004; Edin and Hogberg, 2002). Routine screening remains a controversial issue to health professionals, despite the majority of women patients endorsing this approach (Richardson, et al., 2002). Randomised Controlled Trials have failed to provide evidence to either support or refute the benefits of screening for domestic violence in dentistry (Coulthard et al., 2010) or pregnancy care (O'Reilly, Beale, & Gillies, 2010). Similarly, it is unknown if low intensity interventions in health care settings are effective for women living with abusive partners (Ramsay, et al., 2009).

2.7 Summary

This chapter has presented literature surrounding domestic violence within the context of women as the victim of this violence. The WHO (2005) highlighted the pandemic nature of domestic violence against women. Additionally the strong commonalities shared by women across the globe in terms of their experiences of domestic violence regardless of the country of residence, cultural or socio-economic background has also been identified (WHO, 2005).

The existing literature presents findings from several solitary studies identifying prevalence rates of domestic violence at specific points through the pregnancy/childbirth continuum. However, it appears that there is a paucity of literature demonstrating an understanding of how domestic violence is affected by specific periods of time in a woman's life such as pregnancy. Pregnancy is a unique life event for a woman in which she experiences physical and emotional changes. It is important to attempt to understand if the impact of pregnancy and childbirth when intertwined through the lived experience of domestic violence reveals a different trajectory of disclosure than otherwise evidenced. This gap in existing knowledge surrounding the *timing* of disclosure of domestic violence is worthy of further exploration,

due to the potential benefits this knowledge may provide to the providers of health care for women. The first objective of the study is therefore to explore prevalence rates of domestic violence in a sample of postnatal women, and compare these rates to previous studies conducted within the same geographical location.

It is evident from the literature presented that there is substantial understanding of the effects of domestic violence in terms of the biopsychosocial aspects of a woman's health. Much is also known about how this violence affects both the woman and the newborn baby during the pregnancy/childbirth continuum. However, despite negative health effects many women do not disclose their experiences (O'Campo, Ahmed, & Cyriac, 2008). Domestic violence may be hidden from both family members and health professionals, despite the intimacy of these relationships. The literature alerts us to many of the intrinsic and extrinsic factors that negate a woman disclosing her experiences and thus hiding the violence and associated injuries. The second objective aims to build on this knowledge and explore women's experiences of disclosure of domestic violence.

The Home Office advocates that public services should be more proactive in identifying early signs of violence and also in the provision of better support for its victims (Home Office, 2009). The sociological effects of domestic violence protrude into all areas of statutory responsibilities, thereby directly involving police officers, health professionals, social workers and the criminal justice system. Furthermore, the effects of domestic violence require a consortium of professionals to work together to effectively support survivors of domestic violence. The Department of Health (2010b) clearly alerts us to the statutory responsibilities towards women experiencing domestic violence. This, then, provides the milieu from which women's experiences of their interactions with statutory agencies within

contemporary society can be explored. The final objective of this study, therefore, is to explore women's interactions with statutory agencies when experiencing domestic violence.

Chapter Three: Research Methodology

3.1 Structure of the chapter

This chapter provides a discussion of the methodological approach and the philosophical underpinnings to the two research studies within this thesis. The research has been underpinned by feminist theory, seeking to neutralise the dominant researcher of traditional patriarchal research. This aspect has been discussed throughout the chapter, revealing how it has influenced the methodological decisions in both studies. To assist in the clarity of presenting two research studies which have used opposing paradigms, I have embraced a presentational tactic of weaving together both studies, discussing each aspect of the research process for both of these studies under the same subheading where relevant. Each subsection of the chapter therefore presents the decisions for both studies in sequential order.

The first sections of this chapter (sections 3.1 to 3.3) explore two areas. The first are the principles of feminist research, identifying some of the key assumptions of feminist researchers. Secondly, it explores some of the methodological options considered for the research studies. The later parts of the chapter (sections 3.4 to 3.8) address the specific methodological choices of the two research studies presented within this thesis. A synthesises of how feminist theory has guided the methodological decisions are identified and then justified.

3.2 Feminist research

There are many different concepts embraced by the term ‘feminism’ and it is clear that feminists make sense of the world through different forms such as liberal feminism, postmodern feminism and radical feminism (Crotty, 1998); and therefore it is acknowledged

that feminism is not an 'all encompassing' term. Indeed, Ramazanoğlu and Holland (2002a) argue that feminism encapsulates a diversity of beliefs, practices and politics, whilst Sprague and Zimmerman (1993) identify its connectedness to feminist struggles. Feminist theory is an extension of the term feminism, encroaching on theory and philosophy and focusing on women's experiences of gender inequality. A basic feature of feminist theory research is the amalgamation of political goals with research methodologies to provide understandings of female phenomena which are not reliant on traditional masculine or patriarchal concepts (Ramazanoğlu & Holland, 2002) such as inequalities in pay, access to education, and an elimination of violence against women and girls.

Feminist epistemology acknowledges that feminist knowledge from female experiences is unique to the female gender (Crotty, 1998; Gilligan, 1982). Gilligan (1982) and Harding (1987) postulate that this is because women differ from men in their perceptions of the world, thus leading to different experiences. The challenge of locating a study which explores intimate lives into an established body of knowledge has been identified by Ribbens and Edwards (1998) who argue that applying these established ways of knowing risks the silencing of the voices we are striving to hear. Embracing this epistemology therefore necessitates developing the research around women, ensuring they remain the pivotal focus throughout the research process in order to identify ways in which dominant assumptions and practices that systematically disadvantage them are challenged in order to benefit womankind. Nuances between feminist approaches to research are apparent; however, the crucial underpinning connectedness of researching subjugated women and giving them a voice from their standpoint remains a constant throughout.

Harding (1987) argues that the distinctiveness of feminist research lies in the epistemological approach of the researcher, and that approach can lie within both positivist and naturalist paradigms. Within each epistemology the primary focus of feminist research is to afford women who were previously silenced a voice, reclaiming subjugated knowledge, examining gender inequalities and other practices of power (Brooks, 2007; Riessman, 1993). In order to reclaim this knowledge in achieving an authentic and accurate understanding of women's experiences, it is crucial to begin with women's lives as they themselves experience them (Hesse-Biber & Leavy, 2007). Feminist knowledge has become grounded in gendered social lives and based on theories of power and patriarchy. Brooks and Hesse-Biber (2007: 4) argue that, 'By documenting women's lives, experiences, and concerns, illuminating gender-based stereotypes and biases, and unearthing women's subjugated knowledge, feminist research challenges the basic structures and ideologies that oppress women'. Harding (1987) takes another perspective and focuses on feminist epistemology as the basis for methodology, identifying the feminist standpoint as providing the researcher with a foundation for a methodology for feminist research that is located within an analysis of women's realities. Crotty (1998) supports Brooks and Hesse-Biber's position by arguing that researching gendered social realities brings with it specific issues for consideration, thus impacting on the methodological choices. This is further supported by Harding (1987), who posits that there are distinct methodologies with epistemological implications characterising feminist epistemology. On these grounds one can espouse that embracing feminism to research women is different from traditional research methods. Bohan (1997: 32) confirms this difference, arguing that feminism 'presents traits deemed distinctly women's as indeed different from but equal or even preferable to those that characterize men in general'. Consequently, because of the significant disparity between women's and men's lives, women hold a different type of knowledge. Within women's knowledge there are also a plethora of

differences affecting how this knowledge has been constructed. Feminist empiricists seek to understand feminist issues through a positivist paradigm, whilst feminist standpoint researchers locate women's lived experience at the centre of their research and use this experience to understand both the women's experiences and the functionality of society.

For feminist theorists, domestic violence may be considered as a socially constructed experience. This implies that the participant's experiences are constructed though their social interactions with the world, and that each participant has created their own meaning in different ways, even if in relation to a similar experience (Crotty, 1998). Crotty defines constructionism as 'the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (2004: 42). However, in contemporary feminism the social construction of women's experiences supports the notion that women's suppression is directly related to the wider construction of reality, and that women have constructed their experiences within a male dominated construct.

As with epistemological viewpoints, differences between theoretical frameworks have appeared within feminism too. Theoretical perspectives within a study inform the methodology providing a context for the research process, and identifying the assumptions brought to the study by the researcher (Crotty, 1998). Feminist frameworks rely on a unique assumption about the basis for women's subordination, raising unique questions and providing concepts for examining women's inequality. They provide a systematic way of examining social issues of subjugated women, gaining an understanding of their experiences within a wider social context.

Recognition of the complexities of the research process itself, and the questioning of it, is fundamental to elements of feminist research; and although much feminist research aligns itself within a naturalistic paradigm, the use of a quantitative approach is also embraced (Friedan, 1963; Reinharz, 1992). Feminist research provides a critical stance and underpinning components of include recognition of gender based subjugation, the power relationship between the researcher and the participant, and societal influences. Ramazanoğlu and Holland (2002c: 171) argue that 'Feminist methodology is distinctive to the extent that it is shaped by feminist theory, politics and ethics and grounded in women's experience.' The methodological stance is also shaped by the researcher's epistemological, ethical and ontological views. Using mixed methods reflects a feminist's multi-faceted approach to gather complex and layered data (Leckenby & Hesse-Biber, 2007). Feminists who chose to use a mixed method approach do so to,

> ...[C]ast their net as widely as possible in the search for understanding critical issues in women's lives. The multi-method approach increased the likelihood that these researchers will understand what they are studying, and that they will be able to persuade others of the veracity of their findings. Multiple methods work to enhance understanding, both by adding layers of information and by using one type of data to validate or refine another (Reinharz, 1992: 201).

Leckenby and Hesse-Biber (2007) argue that using mixed methods bridges the void between paradigms, enabling researchers to explore issues involving women from both ends of the paradigm spectrum. Chapter four explores the self-reporting rates of domestic violence using a quantitative paradigm (first study), but then adds to this body of knowledge using a complementary qualitative paradigm and a narrative approach (second study). However, care

has to be taken to ensure that the use of mixed methods in feminist research accomplishes the research goals whilst empowering the participants. The empowerment of the women participants in this study who had experienced domestic violence was a key issue throughout the research process and this is further discussed in this chapter (see section 3.6.2). As the researcher I was constantly mindful of the power relationships between myself and the women. Unlike other qualitative researchers, feminist researchers strive to give previously silenced women a voice (Riessman, 1993). This chapter discusses the feminist aspects of the study and in particular how feminist methods have shaped this work.

3.2.1 Standpoint feminism

Standpoint feminism has developed from the consciousness raising feminist movement that Hughes (2002: 152) argues 'was to enable women to reinterpret past experiences with a view to enabling them to see their world in new ways'. Originating from within the domains of philosophy (Heckman, 1999) and sociology (Smith, 1988), standpoint feminism seeks to situate dominated women in a way that is more accurate and more able to confront oppressive power structures located within society, providing an understanding of how domination is attained (Jaggar, 1997). Standpoint feminism supports the claim that because women's lives and societal roles are significantly different from men's, women offer a unique nature of knowledge derived from their personal and social experiences. Extending this claim, the concept of objectivity relates to the understanding that women are more capable of producing an 'accurate, comprehensive, and objective interpretation of social reality than men' (Brooks, 2007: 66). Locating women as a subordinated group affords women ways of seeing and understanding the world that are different from, and challenge, those of men within a patriarchal system (Hartsock, 1997b).

The challenges and criticisms of standpoint feminism are clearly articulated within the literature and include a criticism involving the generation of gender specific knowledge. For example, Assiter (1996: 348) disagrees with Flax's (1996) view of an absence of 'a feminist standpoint which is more true than previous (male) ones'. Indeed, Hartstock (1998: 44) argues that 'differential male and female life activity in class society leads on the one hand toward a feminist standpoint and on the other toward an abstract masculinity', which Hughes (2002: 158) then elaborates on to argue that the dominant male view is only partial and 'perverse'. Returning to a gender (female) specific issue, Assiter, Flax and Hartsock concur that there is no definitive women's viewpoint. Flax (1990) argues that women require a freedom from domination in all aspects of life such as race and class, not just gender, to facilitate an understanding of their realities and, further, that it is not possible to have a single viewpoint from living within a patriarchal society (Assiter, 1996).

Ramazanoğlu and Holland (2002) identify differences between feminists who challenge the concept of a feminist standpoint, and the notion that researching women from the woman's own standpoint in the context of a gendered environment develops new knowledge. Harding (2004, 1993: 71) acknowledges that whilst '…there is no typical nor essential woman's life from which feminisms start their thought', despite these significant disparities within women's lives, their experiences can be drawn together to provide detailed insights about oppression from within a social context. Assiter (1996: 89) concurs, arguing that 'feminist standpoint allows for a multiplicity of individuals to come together, in an epistemic community, so long as the members of that community share certain values'. However, Brooks argues that standpoint feminism is a distinct approach to gain a deeper understanding of society that has originated from within a woman's experience (2007: 60). It requires a fusion between knowledge and practice, being both a theory for building knowledge and a

method of doing research (Hesse-Biber & Leavy, 2007), and is premised on exploring relations between knowledge and power, seeking to generate knowledge from the nature of experience and social reality (Harding, 2004; Hesse-Biber, 2007). Consequently, as argued by Ramazanoğlu and Holland (2006: 65), 'women speaking *their* truth are situated in relation to forms of power that shape their lives….'. It is argued that feminist research should be practised from the standpoint of women, as it is this standpoint that is critical to the understanding of oppressive systems in society.

Within this community dialogue the multiplicity of the women's views are shared, which can lead to alliances being developed and a synthesis of standpoints being achieved. This is endorsed by Jagger (1997) and Hill-Collins (1990) who argue that knowledge can be generated from women's experiences of inequalities within society. Heckman (1999) identifies that standpoint feminist researchers recognise the differences between women and this is endorsed by Harding (2004), who emphasises that it is specific differences between oppressed women's experiences that contribute to the body of knowledge, not the voices of more dominant groups.

Standpoint feminism centres around the concept that knowledge cannot be generated by solely focusing on women's experiences (Hughes, 2002) and this has been acknowledged within feminism (Harding, 1987; Hartstock, 1997b; Sprague, 2001). Sprague (2001) and (Hughes, 2002) argue that it is generated from within a critical consciousness of reflexivity and struggle. Hartstock (1983) argues that Marxian theories of social domination have a level of symbiotic relationship with feminism in that both strive to understand the effects of domination and associated subjugation.

Exploring women's lived experiences of subjugation offers a unique perspective of their interaction with society and the statutory agencies within. Hill-Collins (1990: 209) argues 'when making knowledge claims about women, we must always remember that it is women's "concrete experience" that provides the ultimate criterion for credibility of these knowledge claims'. This is further supported by Brooks (2007: 56) who argues that this 'concrete experience' should be the entry point for research in order to expose new knowledge offered in women's narratives.

In relation to domestic violence, the woman's experience of non disclosure whilst interacting with statutory agencies provides opportunities to illuminate her knowledge and her skills of negotiating living with an abusive partner, whilst acknowledging that these issues may not have been previously voiced. Standpoint feminists locate women in a way that is more accurate and more able to confront oppressive power structures that serve to dominate women, alongside acknowledging women's individual experiences (Zinn & Thornton-Dill, 1996). Brooks (2007: 75) argues that to achieve this, the feminist standpoint researcher should ensure 'every woman's lived experience and the perspective, or standpoint, based on her experience gains a hearing', and that society should then be critically examined from this perspective.

Throughout this research process I have also been mindful of the power relationships between myself and the women participants, which has permeated each aspect of the research process being discussed throughout this chapter. It can be argued that all the women participants may bring a multiplicity of experiences attributable to their childhood, lifestyle, social class and education to this research. However, being influenced by standpoint

feminism, I have sought to explore and reveal the commonalities within their experiences of living with an abusive partner and their interactions with statutory agencies.

3.3 Data collection methods

This subsection of the chapter explores issues of data collection, in relation to both the first quantitative study and then the subsequent narrative study. Section 3.3.1 explores several valid and reliable tools that may be used to measure the prevalence rates of domestic violence. Section 3.3.2 then looks more closely at narratives and how they are applied within the context of a research process, and explores transcription issues and narrative analysis.

3.3.1 Measuring domestic violence

There are several valid and reliable tools to measure the prevalence rates of domestic violence. It is acknowledged that to identify domestic violence it is necessary to designate specific questions for this purpose (McFarlane et al., 2001). Furthermore, prevalence rates of domestic violence associated with pregnancy appear to be affected by whether the population being sampled is community or hospital based, and also by the assessment tools that are used (Jasinski, 2004). Rabin et al (2009) highlight that despite the many screening tools available for domestic violence, they have been evaluated only in a small number of studies. The ideology of these tools is to assess prevalence rates of domestic violence, which is valuable knowledge to researchers. However a significant limitation with screening tools is the lack of opportunity to assess the risk status of an individual. Thus, practitioners and law enforcement agencies in the UK use risk assessment tools, to assess the level of risk posed to a person experiencing domestic violence, upon which they act. Whichever tool is chosen for the purpose of exploring prevalence rates of domestic violence, it must be fit for purpose.

The Nursing Research Consortium on Violence and Abuse (McFarlane, Cristoffel, Bateman, Miller, & Bullock, 1991) developed the Abuse Assessment Screen (AAS), which measures the frequency, type and perpetrator of domestic violence (see appendix A). The AAS has been used in many clinical and community settings and several epidemiological studies (Campbell, Torres, & Ryan, 1999; Parker, McFarlane, & Soeken, 1994). Used predominantly in clinical settings, the AAS uses five direct questions about being physically hurt; it does not specify a 'partner' thereby capturing more data, is very quick to complete, and has established reliability and validity. Ramsay, et al. (2009) in their systematic review of screening tools for domestic violence identify that when using these tools in clinical settings, the questions and scoring of answers, should be rapid due to lack of available time. Originally the AAS data collection tool was developed as a screening tool for use in prenatal women (Reichenheim & Moraes, 2004), and therefore omitted a question enquiring about experiences in pregnancy itself (Helton & McFarlane, 1986). However, an additional question asking about domestic violence in pregnancy has since been added. Furthermore, the AAS has been modified resulting in the AAS-D which aims to detect domestic violence directed towards women with physical disabilities (McFarlane, et al., 2001). Additionally, the AAS uses specific questions to improve detection rates of domestic violence both before and during pregnancy (Norton, et al., 1995). The Nursing Research Consortium on Violence and Abuse recommends the AAS for clinical use, and it is the only assessment screen for domestic violence that includes questions relating specifically to pregnancy (Rabin, et al., 2009). Acknowledging that domestic violence may commence or intensify in the prenatal or pregnancy period (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006), the use of the AAS then captures this data. This short, self-administered, validated questionnaire enables data to be captured on the past and recent history of domestic violence and the nature of the

violence. Any positive response to the questions posed denotes an occurrence of domestic violence, thereby making this a rapid assessment of experiences. The opening question, 'have you ever been emotionally or physically abused by your partner or someone important to you?' asks simultaneously about emotional and physical abuse, capturing prevalence data on two types of domestic violence. The succeeding question is restricted to actual bodily contact: 'within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?' The third question relates to the current pregnancy: 'since you became pregnant, have you been hit, slapped, kicked or otherwise hurt by someone'? The participant is asked to indicate who did these actions. By collecting data using the AAS, it is possible to assess the extent to which women disclose domestic violence within close proximity to their current pregnancy. The fourth question asks 'within the last year has anyone forced you to have sexual activities'? The final question asks the respondent 'Are you afraid of your partner or anyone you listed above'? Using this self-administered questionnaire has been shown to increase self-identification of abuse in pregnant women from 14 to 41% (Norton, Piepert, Zierler, Lima, & Hume, 1995). The reliability of the AAS has been demonstrated to be equivalent to the revised Conflict Tactic Scale (CTS2) (Straus, 1979). Reichenheim and Moraes, (2004) in their validation test between the AAS and the CTS2, argue that the AAS detected more major incidents of domestic violence that the CTS2. However a limitaion of the AAS was that some physical violence was not dislcosed as restrictive terms used in the AAS resulted in some less severe domestic violence being unreported and a small number of severe cases also being missed.

The Conflict Tactic Scale (CTS2) has commonly been used in non-clinical community samples and measures violence victimisation (see appendix A). It has an original and revised form of the questionnaire, with each being underpinned by a theoretical basis of conflict

theory (Straus, 1979). The CTS2 measures the extent to which specific tactics, including acts of physical violence, have been used. Critical of the CTS2, Stark (2007) argues that although the CTS2 measures actual violence, it disregards issues relating to the impact of domestic violence such as the context of the violence and motivational factors in understanding acts of violence. A comparative study between the AAS and the CTS2 involving women in the postnatal period (within 48 hours after birth) was undertaken in Brazil by Reichenheim and Moraes (2004). This comparison sought to explore the three levels of domestic violence; minor, major and overall, distinguished by positive responses to physical assaults (Feder, et al., 2009). The diagnostic effectiveness of the CTS2 for minor cases of domestic violence was poor, whilst its diagnosis of major cases was enhanced (Feder et al., 2009).

The limitations of the CTS2 include a lack of enquiry about sexual abuse and only recording domestic violence perpetrated by current partners (Kimmel, 2008). The significance of this is highlighted by Walby and Allen (2004) who identify that domestic violence extends beyond physical threats and violence to sexual abuse and stalking, and may be perpetrated by current and previous partners. Sherin et al., (1998) used a modified version of the CTS2 as a comparator against the HITS questionnaire, to test validity and reliability. Feder et al., (2009) identifies that these tests provide evidence of the effective use of the HITS as a screening tool for domestic violence However, they also caution against the accuracy analysis due to the HITS being tested against a modified version of the CTS2, which had four questions omitted. Additionally, the prevalence rates of domestic violence depended upon the definition of minor, major and overall, these being the case definitions for categorising domestic violence (Feder et al., 2009).

The Hurt, Insult, Threaten and Scream (HITS) (see appendix A) screening tool was primarily developed by family practitioners and has been used in a variety of outpatient environments with internal validity and reliability determined as acceptable (Sherin, Sinacore, X, Zitter, & Shakit, 1998). The two languages in which the HITS questionnaire has been tested are Spanish and English. Both versions share good validity and reliability, with the Spanish version being slightly lower (Chen, Rovi & Washington et al., 2007). However Feder et al (2009) purports that this may be due to cultural differences in women's perceptions of the constitution of domestic violence.

In the USA studies using the HITS questionnaire have presented prevalence rates of 38.8% of women being physically assaulted by their partners (Hamberger, Saunders, & Hovey, 1992). Within the UK there has been minimal attention to researching prevalence rates of domestic violence within primary care settings with a paucity of literature on the use of the HITS questionnaire. Limitations in the use of the HITS questionnaire surround the absence of questions about pregnancy and that the questions posed are not time specific, as it is only validated for enquiry about current domestic violence (Feder, et al., 2009). This lack of pregnancy specific questions negated the usefulness of this questionnaire for this PhD research study.

Feder et al (2009) argue that the HITS questionnaire has many advantages over the WAST questionnaire. These include a simpler scoring system compared to the WAST, the use of a simple acronym for ease of memory recall and simplified cut off scores for measuring domestic violence.

The Woman Abuse Screening Tool (WAST) (see appendix A) offers more specific questions about the relationship dynamics than the other questionnaires and also includes a question about former partners (Brown, Lent, Schmidt, & Sas, 2000). Feder et al (2009) identify that when comparing the two English versions of the WAST and HITS, both revealed good reliability. The WAST has been used in conjunction with the Partner Violence Screen (PVS) (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). An absence of specific questions either in pregnancy or the prenatal period limits the use of these questionnaires in this area. These aforementioned screening tools enable the researcher to establish prevalence rates of domestic violence within samples and enable the collection of a limited amount of data relating to the abusive relationship.

The UK advocacy services and law enforcement agencies primarily use a risk assessment tool following disclosure of domestic violence, as these provide a level of assessment of risk, which is an essential component required by the attending statutory agency, to then develop a multi agency plan of support, to reduce the risk of further assault. This requires substantial knowledge surrounding a woman's experiences of domestic violence to assess her level of risk, enabling the practitioner/professional to work as an advocate to support the woman in a co-ordinated action against domestic violence by accessing a range of statutory and voluntary services. The two risk assessment forms commonly used are the Co-ordinated Action Against Domestic Abuse form referred to as the CAADA-DASH (see appendix A) (Co-ordinated Action Against Domestic Abuse, 2012) or the Merseyside Risk Identification Toolkit (MERIT) (see appendix A) (McKenna, 2010), the latter being utilised by the police force in the Merseyside area.

The Association of Chief Police Officers (ACPO) and the Co-ordinated Action against Domestic Abuse (CAADA) combined to produce an evidence based risk identification check

list, the CAADA-DASH (CAADA, 2012), using recognized and consistent terminology. The form uses tick boxes to identify if a person is at high risk of further violence, who are then immediately referred to the MARAC, regardless of gaining consent (CAADA, 2012). Despite the use of this medium to assess the risk status of an individual, CAADA (2012) also advocate the use of a practitioner's professional judgement.

Table 4: Risk factor identification using CAADA-DASH (CAADA, 2012: 1)

Professional Judgement	If a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language particularly in cases of 'honour'-based violence. This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and /or 3 below.
Visible High Risk	The number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria
Potential Escalation	The number of police callouts to the victim as a result of domestic violence in the past 12 months. The criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting

It is anticipated that completion of the CAADA-DASH would ensure effective and appropriate responses to those at risk of domestic violence with an option to refer them to the MARAC (Multi-Agency Risk Assessment Conference). The MARAC serves as a forum for discussion between statutory and voluntary sector agencies, to formulate actions to increase

the safety of the victim through a co-ordinated action plan. Whilst the generalized use of the CAADA-DASH in the UK identifies women at risk, there are some extrinsic limitations with this approach. The form is used as a 'one off' assessment of need, relying on the woman's engagement with the attending practitioner/ statutory officer, to disclose the extent of the violence and abuse being experienced. de la Cruz (2011) argues that some women may not be ready to reveal the full extent of their circumstances. This then results in a false 'low risk' being recorded by the CAADA-DASH.

Of the 250 MARAC's in operation across England and Wales, the Police are predominantly the lead agency involved (Home Office, 2011b). Therefore, the onus resides within this statutory agency to engage appropriately with women disclosing domestic violence, thereby ensuring an accurate representation of her experience when completing the CAADA-DASH. Additionally, it relies upon the professional behaviours of the attending police officer to recognise the severity of the women's situation.

The Merseyside Risk Identification Toolkit (MeRIT) (Nixon, 2008), has been developed for use by Merseyside Police Force to target interventions following domestic violence, aiming to reduce recidivism rates by perpetrators. The completion of this form then feeds into the MARAC process, with the same emphasis for women's safety as the CAADA-DASH.

MARAC's are held every four weeks or more often (Home Office, 2011b), leaving long periods of time between carrying out a risk assessment and meeting to develop a co-ordinated action plan for that woman. There are court mandates that can be put in place to ensure the immediate safety of the women, but apart from detaining the perpetrator, these are reliant on the perpetrator's compliance.

It is evident that high profile domestic violence murders continue despite these measures of risk assessment and multiagency safety planning designed to safeguard women. The investigation into the recent murders of Clare Wood (Horley, 2012), Jane Lee (Brooke, 2008) and Jane Clough (Narain, 2010) all reveal previous multiple engagements with the police force, and some legal provision for safeguarding. However these women were all murdered despite this intervention.

The definitional terms of domestic violence encapsulate several different types of domestic violence that require consideration. Richardson et al (2002) argue that whilst many researchers focus solely on physical violence, others include a broader range of behaviours that fall within the remit of domestic violence. These include emotional and sexual violence and the use of threats. The choice of tool to use within the remit of domestic violence is dependent upon the outcomes required. To measure prevalence, a valid and reliable questionnaire is appropriate. However if risk assessment is required, the CAADA-DASH and MeRIT meet this condition.

3.3.2 Narrative method of inquiry

As the second study used a narrative approach to interviewing, this section looks more closely at narratives and how they are applied within the context of a research process.

Narratives are a medium through which we can transmit our stories, understandings, events, and contexts to another person. They are a social product, being produced by individuals in response to specific contexts, experiences or events. Mattingly (1998: 8) identifies that narratives:

> ...[D]o not merely describe what someone does in the world but what the world does to that someone. They allow us to infer something about what it feels like to be in that story world. Narratives also recount those events that happen unwilled, unpredicted, and often unwished for by the actor...

Although the word 'narrative' has a range of definitions, Riessman (2008) argues that within each one lie dependent sequences. Narratives are retrospective, representing past experiences and providing a medium through which the narrator/participant can make sense of these experiences. This complicated relationship between the past and our memory shapes our own identities within the present. The dynamic process results in the constant moulding of our interpretation of past events and the meanings we find in them in the present.

Narratives often represent lengthy periods of speech through which identities and experiences are conceptualised. Participants in the study shared lengthy narratives about their experiences. Mishler (1986) argues that a principal method of conceptualising an experience is through the use of dialogue and this is especially true of difficult life transitions, gender inequalities and other practices of power (Riessman, 1993). The use of narratives in feminist research encourages an open exploration of a woman's experiences, rather than through the linear questioning approach of interviews considered patriarchal (Ribbens & Edwards, 1998). Furthermore, feminists stress the importance of narratives which give voice to experiences of previously silenced groups of women. Contextualising this within women's experiences of domestic violence, this gender based inequality has been orientated around the use of coercive behaviours to gain control of the female partner, with associated actual or threatened violence. Riessman (2008: 10) states 'Telling stories about difficult times in our lives creates

order and contains emotions, allowing a search for meaning and enabling connection with other.'

This study uses women's narratives to explore how they have constructed their experiences of subjugation: for exploring their meanings from an intrinsic perspective and also the interaction from a wider social position, narrative was an ideal method to gain this insight into the women's lives. However, in reliving experiences, there may be a void between the actual experience itself and the talking about it, affecting their meaning of the event due to its construction at a second level of representation i.e. not the primary event itself but the next closest thing. Additionally, some experiences may be too traumatic to vocalise such as the experiences of subjugation and partner violence. Roth (1993) emphasises the challenges of narrating some extremely difficult experiences. Indeed, Herman (1992) argues that these difficult experiences are, by human nature, removed from the conscious level. For the experiences that are narrated, the women have reconstructed these events in their own words, and within their own contexts. Women's narratives of being abused by their partner represent their own story, and they reconstruct it and relive the experiences. Thus, underpinning the study with a feminist standpoint ensured that the women remained at the centre of, and a focus of, the research, guiding the methodology to embrace these central tenets, and ensuring that the women remained 'in control' of their own experiences of participation.

Throughout the research process I have maintained a reflexive approach, reminding me of my 'personal positionality' and that of the respondent (Brooks & Hesse-Biber, 2007). This approach has been a constant throughout the research, with a focus on how a perceived power may affect the results of this research study. Indeed, reflecting on the women's experiences

and the narrative data collected facilitated meaning to be derived from the data, minimising the influences of my own beliefs or experiences.

3.3.3 Transcription

Statistical validity is less affected by the views of a researcher. According to Tilley (2003) and Wolf (1996), the researcher's philosophical stance does however affect the process of transcription of narratives. Tilley (2003) identifies the importance of the transcribing process, as this may shape and define the text, thereby affecting the analysis of qualitative data. She argues that transcribers interpret the dialogue within an interview and this is reflected in the typed transcription; and that transcribing personal narratives whilst incorporating a feminist approach to transcription is an attempt to truly acknowledge the women's voices as their own with minimal transcribers' influences. It is important for maintaining a feminist perspective and accurately reflecting the narratives of the women that the researcher should transcribe all narratives. Scheurich (1995) argues that narrative analysis is an interpretation of reality by the researcher in response to the data, thus emphasising the importance of accurately recording the participant's words. This is supported by Gubrium and Holstein (2009) who argue that in narrative reality the aim is to capture the maximum amount of verbatim detail to later provide *in vivo* examples of narrative. Gilchrist (1995) in her experiences of researching Aboriginal youth also identified how large amounts of data may be lost in the transcription process if the transcriber does not understand what is being said. Both Knupfer (1996) and Tilley (2003) argue that by re-listening to women's voices, this draws the researcher back into the participants' worlds. To assist in the transcription process, and immerse myself within the women's own words, I chose to use the 'Dragon Naturally Speaking, version 10' voice recognition software package. This process involved re-listening to the women's words recorded on an audio recorder and then speaking those words for the software programme to

type into a word processed document. By listening and then speaking the women's words I became immersed within each woman's story at the time of transcription.

The narratives revealed the experiences of women living with subjugation. Furthermore they revealed the women's experiences of, and responses to, their subjugation from statutory agencies. Using the women's stories it was anticipated that a greater understanding of the coping mechanisms women employ when living with an abuser and how they experience the world would be explored.

3.3.4 Analysis of narratives

Narrative analysis refers to the methods used to interpret text produced within a storied form; however, a certain amount of interpretation is inevitable with the use of narratives, but the degree of interpretation is altered by the method of analysis. Gubrium and Holstein (2009: 2) argue 'the contexts in which stories are told are as much a part of their reality as the texts themselves', suggesting there is no single approach to the analysis of narratives. Moreover there are several methods of analysis which may be applied to narratives, either in isolation of each other or in a combined approach, and Riessman (2008) highlights the advantages of using both a structural and thematic analysis to explore the meaning and structure behind them. Each form of qualitative analysis places a different emphasis on the process, revealing different meanings depending upon the researcher's views of the construction of knowledge (Robson, 2002).

The structural analysis of narratives has a strong relationship to socio-linguistics and aims to identify sequences and structures that recur within narratives (Riessman, 2008). Labov and Waletzky (2003) suggest that personal narratives refer to discrete and restrictive stories that

contain fundamental structures; these can be analysed to identify sequences and structural parts of experiences recurring throughout the narrative. Labov (1972) identifies an analytical framework for this structural analysis consisting of six elements: the abstract (summary and/or point of the story); orientation (to time, place, characters and situation); complicating action (the event sequence, or plot, usually with a crisis and turning point); evaluation (where the narrator steps back from the action to comment on meaning and communicate emotion – the 'soul' of the narrative); resolution (the outcome of the plot); and a coda (ending the story and bringing action back to the present). However, not all narratives contain all six elements, and they may occur at differing intervals, at differing regularities. Labov maintains longer narratives intact, then analyses them closely to determine the component parts and how they interrelate. Merriam (2009) informs us of Gee's (1991) approach to structural narrative analysis, which poses eighteen questions to assist in the analysis and includes the language of the story, and the intonation, pitch and pauses within it. He encourages detailed attention to the tape recording, identifying the prosodic features in each stanza, a stanza being a single topic, typically about four lines long. This approach more fully embraces the narrative compared to Labov's approach, and includes narrative that appears disjointed and without a plot or resolution of the plot (Riessman, 2008).

Using a grounded theory approach to the analysis of narrative enables the researcher to develop theory construction from the analysis (Charmaz, 2006). Charmaz's (1999) approach to narrative analysis identifies that the length of a silence when talking of personal experiences may relate to the depth of suffering, of particular relevance when researching a sensitive subject such as domestic violence. Glaser and Straus (1967) argue that analysis should be independent of, and should precede, the literature review ensuring that the original theory has not been developed from preconceived ideas.

Thematic analysis stands apart from grounded theory and narrative analysis as it seeks to describe shared patterns between qualitative data (Braun & Clarke, 2006), and it was this approach I chose to use. This process seeks to understand a participant's everyday experience, leading to an improved understanding of a particular phenomenon being explored (McLeod, 2001). The method of applying thematic analysis may be realist/essentialist, contextualist or constructionist (Braun & Clarke, 2006). Braun and Clarke argue that 'Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society... thematic analysis can be a method that works both to reflect reality and to unpick or unravel the surface of reality' (2006: 81).

3.4 Research Design

The first study, involving women who had recently given birth and were resident on the postnatal ward within a University Teaching Hospital in the UK, used the AAS with some additional questions enquiring about their current pregnancy. These were accompanied by a participant information sheet explaining the research in lay terms. A list of the telephone numbers for agencies providing support to women who had experienced domestic violence was also included, thereby providing information and potential access to confidential support after leaving the hospital. A pre-addressed envelope was used for returning the questionnaires via the post box on each ward.

The subsequent narrative study involved women who had been a resident of, or supported by, a women's refuge. This study was not related to the health care system, and as such required

different approaches to both ethics and methodological choices than those for the quantitative study.

3.5 Ethical considerations

A feminist approach to ethics has been integral in the exploration and identification of the ethical issues to ensure concordance within a feminist philosophy. Additionally, the WHO (1999) advocate consideration of methodological and ethical considerations when researching violence against women, including protecting confidentiality and ensuring the safety of the participant.

3.5.1 Informed consent and confidentiality

Each participant has the right to make their own decision regarding participation. The emphasis on the woman *herself* making an autonomous decision on participation is particularly relevant to women who have experienced domestic violence, as they have experienced subjugation and coercion. Thus it is acknowledged that women who have experienced domestic violence may have lived with subjugation and coercive behaviours from an abusive and controlling partner, and may accept without questioning the invitation to participate without it being a truly autonomous decision. Indeed, the Royal College of Nursing (2009: 4) states that 'At no time should the individual feel coerced to participate in a study, or be unduly persuaded by the promise of a reward'.

For both studies, detailed information was provided to the ethics committees about how the feminist epistemology underpinned the methodological choices of the study, to ensure that all women participants retained autonomy in their decision to participate and in the information

they shared with me as the researcher. This supported the view of Leavy (2007: 171) who argues that 'Feminist researchers consider issues of difference and research power relations as a part of ethical praxis and make choices that are consistent with their ideological commitments, theoretical frameworks, and practical research goals'. This noteworthy aspect of the research process was addressed by several considerations in both the quantitative and qualitative studies.

Prior to commencement of the first quantitative study, ethical approval was granted by the University Ethics Committee and the National Health Service Local Research Ethics Committee (LREC). Following verbal consent, the women were asked to complete the questionnaire and accompanying questions in private, ensuring a non-coercive response (see appendix B). As I left the woman alone to complete the questionnaire this enabled her to withdraw from the study in private in my absence. Any questionnaires not completed were collected by either me or the attending midwife.

The subsequent narrative study involved gaining ethical approval from the University of Chester (see appendix C). Following this, the refuge personnel at both the refuges supporting the study informed the women as a group at a 'house meeting' of the proposed project, and made available a participant information sheet (see appendix D). Any women interested made themselves known to the refuge personnel, who then contacted me via email or telephone, thereby ensuring a non-coercive approach to participation. The woman decided on when to meet and thus remained 'in control' of her own decision, in contrast to myself making the decision. After discussion about the research study, rationale, and implications such as publication and tape recording, the woman was asked again if she wished to participate. Only after informed verbal consent was given would the dialogue ensue. Withdrawal from the

research at any stage was discussed and the women were made aware that this would not affect their support from the refuge. Additionally, it was made clear that this study was independent of the refuge.

To ensure confidentiality was maintained at all times in both studies, no contact information between the woman and the researcher was shared. All women participating in the first quantitative study were identified by a number for the purposes of recording their information on an Excel spreadsheet.

For the subsequent study the woman's narratives were not shared with other parties, including the refuge personnel. Moule and Goodman (2009: 57) argue that 'researchers should never report data about an individual without that individual's explicit permission'. Thus, discussion with all the women participants included the issues of maintaining confidentiality and anonymity whilst using their data (either statistical data or extracts from their narratives) for research papers and presentations, and anonymity was assured by the changing all names and localities mentioned during either research study. This was particularly pertinent the during the transcription process involved in the second narrative study, and with the women's permission, each of their stories has been included, in part, in the analysis and subsequent research papers. To ensure personal anonymity each woman was invited to choose a pseudonym by which to be known. This rationale gave the woman an identity, yet ensured anonymity, thus resulting in their stories being told in far greater detail than would have been possible without anonymity. By choosing their own pseudonym at the beginning of the meeting between the woman and researcher, it was hoped that this act of empowerment would permeate through our meeting; the choosing of a pseudonym, or a 'false name', often produces a name that the woman can relate to. For example Orange chose her

name due to her liking of colours, while Vyvyan chose her name as she enjoyed watching the television comedy 'The Young Ones' (Jackson, 1982). During Sarah's interview she expressed strong suicidal thoughts. Beauchamp and Childress (2001) term the ethical principle of 'doing no harm' to research participants as non-maleficence, in which there is a duty to protect participants from harm and to uphold an eventual good (Moule & Goodman, 2009). It may be argued that to withhold Sarah's information might have resulted in self-harm; however as a researcher I also had to consider this ethical principle. Furthermore, the ethical principle of deontology relates to morally doing the right thing (Beauchamp & Childress, 2001), and by sharing Sarah's suicidal thoughts, this could prevent her from self-harm. Concerned for her safety I asked Sarah for her consent to inform the manager of the refuge. She agreed to this and therefore the manager was informed.

Beneficence refers to the ethical principle of doing good to the participants and society, and it is hoped that the research should benefit both (Beauchamp & Childress, 2001). There may be positive elements to this research study. From an individual perspective, through their narratives, each participant may conceptualise their experiences (Mishler, 1986), and further, may derive meaning from them and make connections between their experiences (Riessman, 2008). From a wider societal perspective, it was anticipated that health professionals and support agencies would gain a better insight and understanding of the women's experiences of both living with a perpetrator of domestic violence, and also attempting to access support from statutory agencies in contemporary society.

This section addresses how the integrity of both the quantitative and qualitative studies may be challenged and addressed. Reliability and validity are rooted in a positivist paradigm, and they need to be redefined for use in studies located within a naturalistic paradigm. Lincoln and Guba (1985) articulate this point clearly; they posit that whilst the terms 'reliability' and

'validity' are essential aspects for identifying quality in quantitative paradigms, research located within a qualitative paradigm also requires its integrity and quality to be assessed through different measures. Domestic violence is an emotive subject which may present danger to both the researcher and participants; therefore consideration of these issues has been paramount in developing the study.

3.5.2 Validity and reliability

This study has utilised different resources to gain information including a survey and then narrative interviews, thereby increasing its credibility. However the principles of validity address the accuracy of the first quantitative study, in which the data collection tool measures what it is supposed to (Moule & Goodman, 2009). Researching the prevalence rates of domestic violence in clinical settings has predominantly used the AAS, as it is very quick to self-administer, and has established reliability and validity, being originally developed as a screening tool for use in prenatal women (Reichenheim & Moraes, 2004). Furthermore, the AAS has been used in many clinical and community settings and several epidemiological studies (Campbell, et al., 1999; Parker, et al., 1994). In relation to the first quantitative study, issues of reliability were considered, and ensured that the data collection tool (AAS) was consistent and produced reliable data each time. Using this data collection tool in the postnatal sample ensured that a fair and valid comparison between this sample and the previous samples was achievable. Prior to commencing my PhD, I had completed surveys into the prevalence rates of domestic violence in clinical areas accessed by women, and using the AAS for data collection. Therefore the data collected in the first study of this PhD ensured that any variation in the comparison of the results (section 4.3) was due entirely to the responses of the women i.e. the reporting of domestic violence, and not to the instrument

itself. The ethical dimension of validity and reliability relates to the provision of trust and confidence in the data collection, analysis and the researcher.

3.5.3 Misrepresentation and misinterpretation

Exploring the trustworthiness of the participant's story in the second qualitative study, Riessman (2008) argues that, although narratives are incomplete truths, the trustworthiness of it lies within the methodological and ethical considerations that have informed the study. The methodological implications for this study have been discussed within this chapter, and this discussion now explores the trustworthiness of the narrative itself.

Due to the interpretive nature of qualitative research the narratives presented are only sections of the whole chosen by the researcher, and the issue of misrepresenting the woman's words or feelings needs consideration. There have been several measures to ensure accuracy of the representation and interpretation of the women's voices. Richards and Schwartz (2002) identify the influences of epistemological commitments in influencing this, therefore a negotiation is required between the researcher and the woman. Padgett (2008) identified three methods of enhancing rigour and trustworthiness including member checking, peer debriefing and an audit trail. Member checking was offered to all participants, although only one woman requested a copy of her transcript. This implies that the other participants either placed implicit trust in me as a researcher or they did not wish to revisit their stories. The risk of misinterpretation increases when a researcher works in isolation (Richards & Schwartz, 2002) and is unaware of any biases brought to the study. Hence, as PhD research, the study has been monitored by a supervisory team, with regular discussions and peer debriefing surrounding each phase. Secondly, debate about the findings has emerged through supervision of the study, and following peer review of research papers. This has constructively challenged my

interpretations of the data, and provided internal and external reliability to the outcomes. A clear audit trail throughout the data collection and analysis phase has been maintained, and details of this have been included in section 3.7.

3.5.4 Research governance issues

Recognising the plethora of ethical issues that relate to researching vulnerable women and researching women's experiences of domestic violence, this section identifies these challenges and then describes the strategies employed to address them within the feminist influences underpinning the study.

3.5.5 Risk management

Issues of safety are paramount when researching domestic violence. Concerns surrounded the safety of both the woman and me, acknowledging the potential for harm from a perpetrator or indeed sharing of experiences. Safeguarding women in the postnatal period has been discussed in section 3.6.2. To safeguard the woman all meetings were held within the refuge, itself a place of safety. No contact was made with any partner or family member. The women participants and I did not exchange any contact information; however, my work telephone number and email address were accessible from the participant information sheet, and if a woman chose to receive a copy of her transcript, an address (electronic or postal) was shared. Several considerations were necessary including empowerment of participation, choosing what to narrate and deciding on the length of meetings. Feminists have argued that a woman researcher may have more power than a woman participant, though Cotterill (1992) suggests that the power balance within interviews is dynamic in that both the researcher and participant may be vulnerable. This power imbalance may be apparent in all research; however the significance of this potential imbalance could be greater when researching

women who have experienced domestic violence, due to their previous experiences of subjugation by their partner. These issues have been addressed through adopting a feminist approach to the research whilst emotional support following the interview was provided by the refuge personnel. It was an explicit understanding that no details of the narratives were shared with the refuge staff, although it was agreed that excerpts from their narratives could be used for publication.

For both studies, all data was managed in accordance with the Data Protection Act (1998). Statistical data was password protected on a personal computer. Paper copies of the questionnaires used in the first study were securely locked away. The tape recorded narratives from the second study were transcribed by me and then also password protected on a personal laptop. Pseudonyms were used throughout, but when identifiable information such as children's names or place names was narrated, these were changed on transcription and anonymity was assured to safeguard the women and children from the perpetrators who may stalk them and seek revenge.

As the researcher, it was important to safeguard both my physical and emotional health during this study. Measures taken to ensure my physical safety have previously been discussed. Emotional support was provided through supervision.

3.6 Research settings

The first study took place within a large District General Hospital within the UK. All the women involved in the subsequent narrative study were, or had been, resident within one of two refuges, also situated in the UK. Refuge A appeared to be significantly more proactive in

involving the women in projects such as art work, the use of the local leisure pool etc. They were also very supportive of this research project and therefore more women were informed about the study; the majority of the women (13 out of 15) involved in this study were being supported by refuge A whilst two of the women were supported by refuge B.

Refuge A occupies three terraced houses that have been internally converted to form one large building. Deceptively, from the outside these terraced houses appear unchanged. It is open 24 hours a day, 365 days a year, offering support to 12 families who have experienced domestic violence, both from the immediate locality, but also from elsewhere in the UK. Each family has their own bedroom and bathroom. Communal areas include the living areas and kitchens. Other facilities include a free and confidential helpline, playroom and sensory room with child care workers, counsellor for the women, and floating support providing continual support to women living within the community who are living with an abusive partner. The refuge also negotiates free or reduced entry for residents to access a local fitness centre, swimming pool and days out. As a registered charity the refuge is funded by several different organisations.

Refuge B is a purpose built refuge, open 24 hours a day, 365 days a year, and offering support to 12 families who have experienced domestic violence. Each family has their own bedroom with a private bathroom. There are communal sitting and dining areas, an area for children with toys and books, and an area designated for older children with computers and games. The refuge is funded by a charity which together with rental income covers the core staffing and running costs of the refuge. As a charity it is involved with the running of the refuge, operating a 24 hour helpline, and taking part in a Multi-Agency Risk Assessment Committee (MARAC) involving both statutory and voluntary agencies to record incidents of

domestic abuse, collaborating with the agencies to safeguard both mother and children. Facilities available to the residents include a counselling service, therapeutic programme for children, outreach service for ongoing support, crèche for younger children and a youth club for 10–16 year old children who have experienced domestic violence.

3.6.1 Sampling

Denscombe (2010) argues that it is inadequate to assume that the sample represents the general population; rather, the sample needs careful selection based on confidence intervals. Quota sampling depends upon the researcher to hand out the questionnaires until the quota is complete, thus, no participant becomes 'surplus to requirement' (Denscombe, 2010: 13). In terms of researching domestic violence within a hospital environment, this type of sampling works favourably to increase the total number participating. If a woman declines participation, this is recorded, but invitation to participate continues until the full quota of questionnaires has been handed out. Proportional quota sampling is used to calculate the quota required for each clinic. This represents the population by sampling a proportional amount of each. Thus, applying this to domestic violence, previous studies have demonstrated prevalence rates of between 20 and 25% of the female population (see chapter two). Based on a confidence interval of 95%, the quota for the postnatal sample (and also the other samples detailed in chapter 4) was calculated in this way by a statistician; based on this calculation, five hundred women were invited to participate. All women resident on the postnatal wards were invited to participate, regardless of the outcome of their pregnancy or method of delivery, until the quota was complete. Women were between one and five days postnatal.

The subsequent study involved fifteen women, all of whom had experienced domestic violence within a heterosexual relationship. Each woman had one or more children by the

abusive partner or a previous partner. The women varied in age and life experience. A précis of each participant is presented in chapter five, providing some contextualisation for the excerpts in chapter's five to eight whilst maintaining anonymity. The women who participated brought personal life experiences to the interview, although the common element was the experience of domestic violence at some stage in their life. The duration of the violence ranged between twelve months and thirty six years, and the sample consisted of fifteen women; I felt, as the researcher, that this was a large enough sample from this group of women (DeVault, 1999). Table 7 in chapter five provides an overview of each woman's personal circumstances at the time of their interview.

3.6.2 Negotiating access

The primary issue for consideration in accessing a sample of postnatal women was to maintain the safety of the woman and the researcher. Due to the pernicious nature of the perpetrator there was a limited opportunity to ask women to participate in the research. Recognition of these issues was central to the methodological choices. Perpetrators of domestic violence are manipulative and suspicious.

Negotiating access to the postnatal women who participated in the first study necessitated going to the wards at an optimum time each morning before any visitors were allowed access, and when the women were awake as breakfast had already been served. Therefore, as the women were unaccompanied, I chose this time to invite them to participate in the study. Anonymity was assured as no personal information was recorded on the questionnaires and verbal consent rather than written consent was obtained. This ensured that if a perpetrator did become aware of the research study, the women's identity on all the questionnaires remained anonymous. Furthermore, the address on the returning envelope listed a department, not a

member of staff. Thus, as the researcher, my identity became anonymous. Confidentiality was maintained by ensuring the data was not shared with any third party. All participants were informed that they could opt out at any stage and this would not affect the care that they received. The self-administered questionnaires were to be completed in private and returned in a pre-addressed envelope within the internal postal system. Addressing security, each woman was asked to refrain from mentioning the study to her partner or family until she left the hospital, in order to prevent transmission of information about the study to extended family as this might put some women at risk of harm by an abusive partner. It is acknowledged that as the researcher I had no control over this. The RCN code of ethics (RCN, 2011: 6) addressed issues of beneficence, referring to ' researchers must take great care to protect the interests of participants...'. Consequently, any woman who was invited to participate in the study, regardless of their participation, was provided with access to continuing and confidential support including a list of support agencies that accompanied each questionnaire. Furthermore, all health care professionals in the unit had previously received additional training on domestic violence, and the medical staff and midwives in those clinical areas were informed of the research project.

The narrative study involved negotiating access to women in the community and this posed separate issues. Initial contact was made with the manager of refuge A. An initial visit was arranged to meet the manager, share the research aims and to discuss appropriate methods for recruitment. The nuances of domestic violence were significant in the development and consequent choices for negotiating access. Following written consent from the manager to enable the women to be asked about participation, ethical approval was then obtained from the University of Chester Ethics Committee, with only one amendment required following submission to secure approval. This research study involved a group of women who had been

living in an abusive relationship. The risk of a perpetrator discovering his partner had participated in research was of primary concern. This was addressed by only accessing women who were being supported by a women's refuge and had therefore left their abusive relationship. The participant information sheet was subsequently sent to the refuge manager, who shared it with any women residents in the refuge or at therapy groups. Women were informed that this study was independent to the refuge, and that it was based on a voluntary system of self-selection; any woman who spontaneously volunteered to take part notified the manager who then contacted me. A mutually convenient meeting was then arranged at least twenty four hours after volunteering in order to give the woman time to reflect on her decision. All meetings took place within the refuge. Personal contact recruitment was not chosen. Issues such as the 'unknown researcher' effect and associated researcher power which makes it difficult for participants to judge whether to take part on the basis of a telephone call or email did not apply. However, it is acknowledged that it is largely unknown how many women declined to meet the researcher due to the methods employed in recruitment.

3.6.3 Pilot study

A pilot study was not conducted for the quantitative study as I had recently conducted several research studies using the same methodology in different clinical areas within the same hospital.

A pilot study was conducted for the narrative study with the initial idea of commencing dialogue with the women using one of three methods: a vignette depicting a domestic violence incident, manipulated within which were emotions of childbirth, maternal bonding and a hesitation on disclosing; second was a graph demonstrating the phenomenon

surrounding significantly lower reporting rates in the Booking In Clinic and in the postnatal period (see chapter four); and the third method was the approach of quietly waiting for a woman to initiate dialogue.

The inaugural interview for the second study took place in February 2009 when three women volunteered to meet me. All three women had acknowledged to the refuge staff their wish to participate in the study on my first visit to the refuge. Each woman talked in private, and during each narrative interview within a short period of time the women's displeasure at reading or utilising the vignette and graph was clearly evident. It was apparent that they were resisting any attempt to engage in dialogue about the vignette or graph; each woman briefly glanced at these data collection tools and quickly disregarded them to rapidly turn to their own story, wanting to share their own personal experiences with me. At no time did the women choose to return to these. Embracing a feminist approach to this study, it was important to be able to discontinue with the agenda and be directed by the woman in her dialogue (Hesse-Biber & Leavy, 2007). Consequently narrative interviews were then conducted with the woman commencing the dialogue at her chosen juncture. Guenette and Marshall (2009) argue that participants move to a position of interest in order to tell the story.

3.7 Data collection

The first study explored domestic violence within the hospital environment. This was challenging primarily due to the limited time period in which to invite a woman to participate, and then ask her to complete a self-administered questionnaire, whilst ensuring that absence of all partners. There are also many different questionnaires to capture data on prevalence rates of domestic violence, yet certain parameters are specific to this field of study. Denscombe (2010) argues that it is shrewd to limit the questions asked in a

questionnaire as a lengthy one may deter participation, and to ask only questions which are considered vital for the study. For the purpose of this study the self-reporting prevalence rates of threats or actual violence by an intimate partner against a woman were being explored. Thus, an appropriate questionnaire was sought for this purpose. Due to the limited time available to approach women, a questionnaire with closed questions was necessary. The Abuse Assessment Screen (AAS) (McFarlane, et al., 1991) was used enabling self-reporting rates of domestic violence to be measured (see appendix A). Rates of domestic violence associated with pregnancy appear to be affected by whether the sample is community or hospital based, and also by the assessment tools used (Jasinski, 2004). The AAS, having been used in many clinical and community settings and several epidemiological studies, was used for data collection (Campbell, et al., 1999; McFarlane, et al., 1996a). The AAS is a short self-administered and validated questionnaire using five closed questions to assess past and recent history and nature of domestic violence, as discussed in chapter three, section 3.3.1. By collecting this data, it was possible to assess the extent to which women disclosed domestic violence within close proximity to their current pregnancy.

The second narrative study was also concerned with ensuring the woman participant remained in control of her decision, making an autonomous informed choice on her decision to participate. Within the context of the narrative interview, the women participants remained in control of the date and time of the interview, and this was a fluid arrangement. When meeting a woman the study was again introduced and verbal consent obtained to participate and to audio record the meeting. The woman was encouraged to commence her dialogue, and to resume interrupted dialogue, whenever and wherever she chose, to stop the meeting at her discretion, and to discuss only topics she chose to share. Sarah chose to be accompanied by

Scarlet at the beginning of her meeting with me, but it soon became apparent that she had changed her mind, and Scarlet then left the room.

Following the pilot study, regular visits were made to refuge A, and a total of thirteen women from this refuge agreed to participate. Refuge B was also approached and discussions ensued with the manager. Following written support from this manager, and additional ethical consent, the same process as with refuge A was followed. Only two women (Vicky and Stacey) participated from this refuge. All the women were offered a copy of their transcript, to be sent to them through their choice of delivery method (email, post, hand delivered). All but one of the women declined the offer.

I responded to each woman's dialogue with non-verbal communication, acknowledging her dialogue without verbal interruption. I asked questions to either clarify something that she had said or to carefully probe that subject, but was guided by the women's responses so I maintained a sensitive approach to her position. The line of conversation was dictated by the women as was the pace of the conversation (DeVault, 2004). This approach enabled the woman to direct the dialogue, avoiding any further control or exploitation from myself as the researcher (Josselson & Lieblich, 1999). I was mindful of my own agenda in terms of wanting to understand the phenomena discovered in the first study. Hesse-Biber argues that the researcher must be continually attentive and be prepared to drop their own agenda and follow the woman's talk (Hesse-Biber & Leavy, 2007). I was influenced by Hesse-Biber's approach and was led by the woman's dialogue, but asked for further clarification if required as many disparate elements were combined. The narrative interviews varied: some women chose to talk about all the domains presented within chapters five to eight (findings) (Lily, Poppy), yet others barely covered them at all (Rose and Louise). Moreover, many of the

women were hesitant and staccato in their speech at times. If a woman appeared upset or uncomfortable during a thread of her dialogue, I did not challenge her for further explanation; for example, Rebecca became distressed when she narrated her experience of sexual abuse by her partner, and chose not to continue her dialogue about this experience. De Vault (2004b: 235) argues that 'this halting, hesitant, tentative talk signals the realm of not-quite-articulating experience, where standard vocabulary is inadequate and where a respondent tries to speak from experience and finds language wanting'.

Previous research studies have demonstrated the prevalence rates of domestic violence across socio-economic groups, and I deemed it unnecessary to ask the women participants for this information (see section 2.2.1). Tolman and Szalacha (1999) argue that asking inappropriate or insensitive questions may negate a woman's narrative on other sensitive issues, and therefore I was selective and sensitive about asking questions. Each narrative interview lasted for as long as the woman chose, and was conducted within a private room within the refuge. My meetings with the women lasted between 25 minutes (Sarah was rushing out to the shops) and one and a half hours (Lily). When required, childcare was provided by the refuge child worker to enable the woman to speak freely in the absence of any children.

The tape recorded narratives were transcribed verbatim by me with the use of the Dragon Naturally Speaking software programme, when possible before commencing the subsequent interview to ensure the richness of the data was captured. Transcripts of the narratives included any dialogue between the woman and the researcher that took place when meeting a woman. The transcription preserved any duplication of words or overtalking. The overlapping speech in some of the narratives suggests that the women felt empowered to overtalk the researcher, supporting the effectiveness of a feminist philosophical framework

within this study. Any words emphasised by the woman were typed in italics. Silences of less than three seconds were recorded as a pause; any longer, they were recorded as a silence, whilst silences of more than approximately six seconds were recorded as a long silence. To preserve the context of the dialogue, all nonlexical utterances (such as 'err') and discourse markers (such as 'you know') were also transcribed verbatim, in line with De Vault's (1990: 227-250) suggestion that the hesitancy within the women's talk should be included as a reflection of the 'unspoken word'.

3.8 The process of analysis

3.8.1 Statistical Analysis

The first study, a survey, generated numerical data that required statistical analysis. Statistical data may be ordinal, nominal, interval or ratio in nature and this affects the statistical tests required to make meaning from the numbers. Furthermore, the data may be parametric or non-parametric, the former assuming the sample is drawn from a population with a normal distribution (Kinnear & Gray, 2000). However, non-parametric data does not make assumptions about the population distribution.

To support the statistical calculations, the analysis for this first study used The Statistical Package for Social Sciences version 16 software. The raw data collected was in categories, e.g. employment status or age group. Following a process of coding, a number was attributed to each category in order to carry out statistical tests. By forming groups within the questionnaire results, this has resulted in my own imposition of grouping the data; however, this was necessary to gather relevant data together to test against other variables. The data captured in this study included many variables such as age, type of infant feeding, ethnicity,

commencement of smoking and drinking in the pregnancy, and partner being present at delivery. This multivariate study had more than three variables being measured (age, employment status, ethnicity, smoking habits, alcohol intake etc.) against the dependant variable (experience of domestic violence). The statistical analysis has been supported by a statistician throughout. The initial process of statistical analysis began with exploring any association between an independent variable and the dependant variable (domestic violence) using the Pearson Chi Square Test. If an association was found, the strength of this association was measured by applying the Cramér's V Test to the data using the asymptomatic standard error assuming the null hypothesis. The Kruskal-Wallis Test was then used to establish if one of the subsets was unusual for that independent variable. However, this test produces a mean rank for each group, which indicates which group has more or less of a variable than other groups (Kinnear & Gray, 2000). Thus, each variable was tested (employment status, age) to yield the mean rank. Finally, the Mann Whitney Test compared the mean ranks from each subset against each other, thereby determining which subset was unusual within the data set.

3.8.2 Narrative Analysis

The second study involved listening to the women's voices and transcribing the narrative interviews. This section now addresses the process of thematic analysis including constructing themes, editing interview material and writing about the women's experiences.

Plummer (1995: 87) argues that 'For narratives to flourish there must be a community to hear, that for communities to hear, there must be stories which weave together their history, their identity, their politics'. Within the narratives I have sought to retain the context in which the women talked, and yet weave similar experiences together to present a more meaningful

representation of the women's experiences of their journeys of living with domestic violence. The process of analysis has been influenced by standpoint feminism in presenting an opportunity in which subjugated women's voices can be heard. In cautionary words Braun and Clarke (2006) dismiss the view that researchers can 'give voice' to the participants. However, contrary to this claim, feminist researchers actively seek to elicit the nature of subjugated women's experiences, and the 'giving' voice reflects the attempts to exhibit their otherwise silenced and unrepresented voices and experiences. Brooks (2007) identifies that in order to achieve this, each woman's experiences must be explored; therefore, by using a thematic analysis, each of the women's narratives has been explored equally, searching for themes and patterns across all the narratives (Braun & Clarke 2006). Reicher and Taylor (2005) argue that the theory and method of thematic analysis must be applied rigorously, a point supported by Braun and Clarke (2006) who devised a fifteen point checklist to demonstrate a good thematic analysis. Adopting a more inductive approach to the thematic analysis, the themes are strongly linked with the data itself (Patton, 2002). Braun and Clarke (2006) refer to this inductive analysis as a process of coding devoid of the researcher's analytical preconceptions though not in the absence of epistemological influences; this is an attempt to theorise patterns within their broader meanings (Patton, 2002). The six phases of thematic analysis (Braun & Clarke, 2006), identified in Table 5, have been followed and are now described in more detail.

Table 5: The six phases of thematic analysis (Braun and Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

The initial stage of Braun and Clarke's (2006: 87) thematic analysis involves the transcription process which has already been discussed in section 3.3.3. The first level of analysis, prior to the commencement of coding, was my immersion within the data achieved by interviewing the women myself and listening to their stories. Scheurich (1995) highlights the importance of accurately recording the participant's words, therefore I transcribed verbatim the audio recorded interviews, and then listened to the recording again whilst reading the transcription, ensuring that the transcription was an accurate recording of what was said and, further, that I was fully immersed within the data. Corbin and Straus (2008) highlight the benefits of this immersion in the data as increasing the researcher's sensitivity to the data, thus preventing incorrect and premature analysis. This immersion enabled me to recall the women's stories and begin to be aware of some of the possible evolving concepts from within their stories, making notes in the margins of the transcripts to highlight words for further exploration.

The second phase of Braun and Clarke's (2006) thematic analysis involved generating initial codes within the transcripts. Each transcript was given the necessary time required for me to become very familiar with the narrative. Treating each woman's story equally I chose to manually code the transcripts, using different coloured pens and using notes. This constant movement between all the transcripts continued until all the data extracts were coded. I then cut and pasted these data extracts from the narrative into separate word-processed documents representing each code, but ensuring each extract was identified with the participant who spoke the words to ensure I could revisit the origin of the extract. By developing codes within the narratives, I began to remove large sections of text from different transcripts and place them together under a shared code (Riessman 1993). I was interested in the contents of the narratives exploring the ways in which the women framed their meanings within their stories and presented them (Hesse-Biber 2007). Indeed, Bryman (2001) argues that by maintaining the extract within the surrounding data this maintains the context of the words spoken. The process of sifting through all the transcripts looking for codes was a dynamic and continuous process, which then developed to the formation of themes. An example of data extracted and the initial coding system is presented in Table 6.

Table 6: Data extracted from narrative, and coding applied to the extract

Woman's pseudonym	Data extracted	Allocated code
Daisy	4 or 5 months into the relationship when we were living together. You see I was vulnerable at the time when I first met him because I had been with an ex-partner which I didn't have domestic violence from but it was verbal I was getting off him but we were together four years and then me and him split up and I think it was only like two weeks after me and him split up I moved in with the current one you see so I was vulnerable and this was like too quick	1 Meeting partner 2 Vulnerable 3 Verbal abuse
Daisy	My partner was a postman, he was nice when I first got with him and that you know he treated me wonderfully like a princess and everything was great and then he was into, he started to get into drugs and drink which changed him to being a domestic violent person	1 Beginning of relationship 2 False start 1 Feeling very special
Lily	He is like ringing me pestering and pestering so and erm with having the children young I couldn't have that anyway and what I couldn't have I didn't miss, so I sat there really nervous at the table and he would be saying there's no need to be nervous and he would pick his knife and fork up and bang it on the table, and I felt absolutely humiliated, and kept saying don't do that don't do that. And I didn't know what cutlery to use and I had to wait for him to start eating	1 Beginning of relationship 2 Vulnerable
Lily	I gave in and agreed to go for a meal with him. Now when we went for the meal, I had never been for a meal, I had never been on a night out because I had lived like quite a quiet sheltered life	1 New experience
Stacey	Erm and then I met my partner and things were great, he treated me like a princess, you know everything was amazing and then I found out in the October just after we had got together that I was six months pregnant to the previous partner.	1 Feeling very special 2 New pregnancy
Tulip	We got together through friends (long silence) and when we first got together it was quite good really, he made me feel special and all that	1 Feeling very special 1 Beginning of relationship

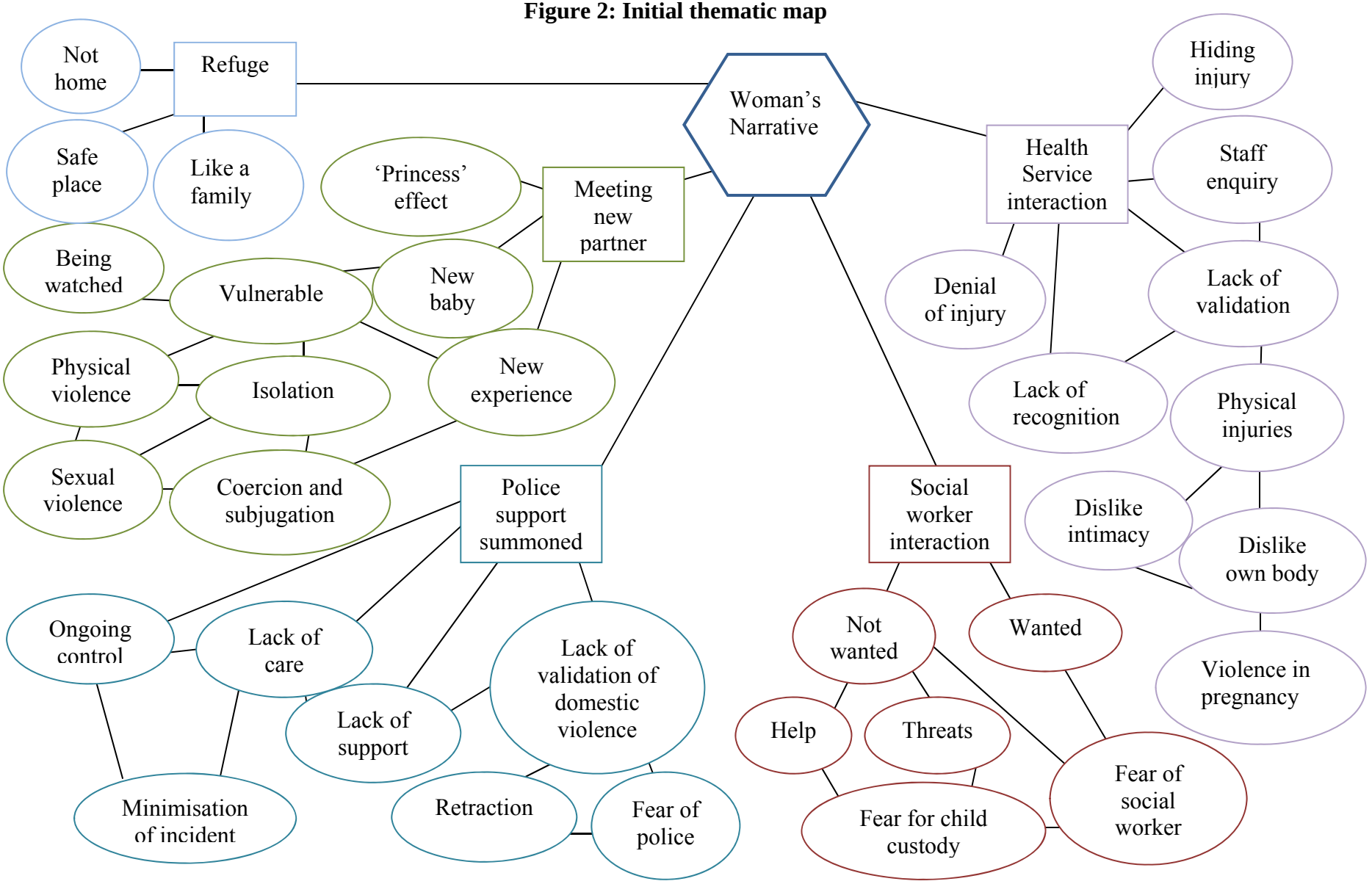
Having completed coding through all the transcripts, the third phase involved collating codes into potential themes by gathering all the relevant data into each theme (Braun & Clarke,

2006). Using a thematic map, themes continued to develop from the initial codes, building the relationship between themes, and considering what constituted an overarching theme and what constituted a sub-theme (Braun & Clarke 2006).

The process of thematic analysis continued though the refinement of the themes during what Braun & Clarke (2006) describe as phase four. When refining the themes I found that some of the potential themes identified in phase three could not be substantiated as a theme due to a lack of data. Other themes, such as the women's feelings towards breastfeeding, were broken down further as there appeared to be three interlinking sub-themes regarding this issue (see chapter six). The two levels of analysis at this stage involve firstly reviewing the coded data extracts for each theme to decide if they form a coherent pattern (Braun & Clarke 2006). The second level is then to consider the validity of the themes in relation to the complete data set, this process being assisted by a thematic map. This process can be seen through the initial coding stages in Figure 2, and then refined further in Figure 3 as the codes are compared to the complete data set.

In Figure 2, the data analysis originated from the women's narratives (see hexagonal shape). The emerging themes are represented in the square shapes, and any sub-themes are then named in oval shapes. Each emerging theme and its associated sub-themes are colour co-ordinated for clarity. The colours were randomly chosen, but one colour has been used to represent one theme and its associated sub-themes. The connecting lines have assisted in the analysis by identifying potential linkages in the sub-themes, but at this stage of the analysis did not represent any hierarchy or continuum.

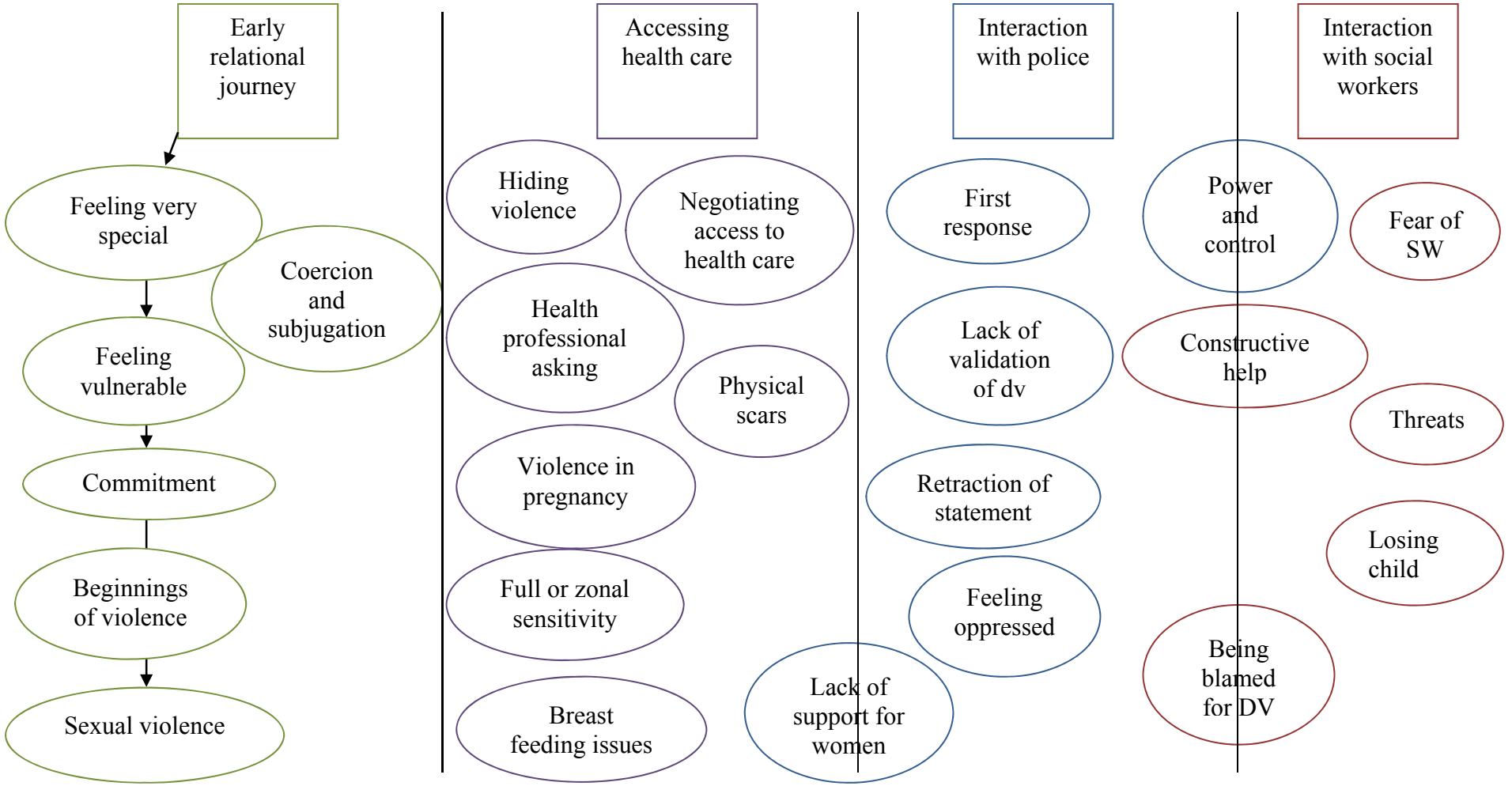
Figure 2: Initial thematic map



The penultimate phase, phase five, involves defining and naming themes (Braun & Clarke, 2006). This dynamic process followed completion of the final thematic map (see Figure 3), and was influenced by striving to give previously silenced women a voice (Riessman, 1993) and whilst presenting an authentic and accurate understanding of each woman's experience (Hesse-Biber & Leavy, 2007). The clearly defined themes were then used to inform the final writing stage of the analysis. The themes and sub-themes are presented in Figure 3.

The final stage of Braun & Clarke's (2006) thematic analysis is the final report writing, presented in this thesis in chapters five to eight inclusive. Each theme and its associated sub-themes have been presented as separate chapters. The inclusion of data extracts provides vivid *in vivo* examples, helping the reader become closer to the women's experiences (Bogdan & Biklen, 2007), and relates the analysis to the research question and literature. Hesse-Biber (2007: 346) notes 'the language of the author can produce it [the writing], but the experiences of 'the other' can guide the process. Both voices will undoubtedly be interwoven into the script, and they will ultimately work together to empower those who need to break the piercing silence of the past'.

Figure 3: Final thematic map showing the four main themes and associated sub-themes



The arrows connecting the sub-themes within the early relational journey represent a pathway process. No priority order appears to exist in the three other main themes. Overlapping sub-themes are presented as ovoids crossing the lines of two main themes.

3.9 Conclusion

A feminist standpoint epistemology informed the study, being the basis for the methodological decisions, thereby ensuring that the women's experiences became the central point around which the study developed. By exploring how the women constructed their experiences of subjugation and exploring their meanings, from both an intrinsic perspective and the interaction from a wider social position, it was anticipated that this study would produce a more complete response to the research aims identified in chapter one.

Continuing the feminist philosophy I sought methods that would empower both the women participants and the research whilst informing the study. Contrary to being voyeuristic research, this study embodies the feminist philosophy of being concerned about subjugated women, striving to empower them and provide them with a voice, to forge social change for their benefit.

To provide some contextualisation of the excerpts used in these subsequent chapters, table 7 (chapter five) presents a précis of each woman, whilst maintaining anonymity. Chapter four presents the findings from the first quantitative study and the subsequent chapters (five to eight) present the findings from the second narrative study. Using excerpts from the women's narratives, chapter five explores their experiences of the early relational period, of the use of coercion and subjugation to engage a woman in a relationship with the intention of using violence. The structure of this chapter follows the journey of the woman, her experiences from this early relational period through to the exposition of violence and domination. The remaining three chapters (six, seven and eight) then widen the perspective, exploring the women's interactions with the health service, social workers and the police respectively.

Chapter Four: Findings

4.1 Introduction

The literature presented in chapters two and three includes an overview of contemporary research papers that explore both data collection tools used to measure the prevalence rates of domestic violence and other influencing factors that impact on this field of study. This chapter refers to some of this literature whilst presenting the findings from the first of the two research studies within this thesis and focuses on the first aim of the research. By using a mixed method approach, this is reflective of the many aspects employed by feminists in gathering complex and layered data (Leckenby & Hesse-Biber, 2007). Thus, this quantitative data has presented the first layers of this knowledge. These quantitative findings provide a backdrop to the subsequent narrative study, which explored through women's narratives the context of, and effects of, domestic violence.

This first study explored the reporting rates of domestic violence by a sample of postnatal women; the survey was undertaken using a positivist paradigm, underpinned by a feminist epistemology. The findings from this study are presented in section 4.2. Whilst these findings are interesting, the lower prevalence rates have previously been reported in other samples (chapter two, 'literature review'). Thus, in isolation, these findings are limited in offering new knowledge. However, the postnatal study was one of several undertaken within a two year duration that replicated the use of the data collection tool, with the sample being drawn from the same geographical location (see Keeling, Birch & Green 2004 & Keeling & Birch 2004). The results from this quantitative study presented in this chapter, was the first of two studies undertaken as part of a PhD. However, immediately prior to the PhD commencing, I had undertaken several other smaller research studies, the data from which, I was able to use

for comparison purposes. Hence, it is within these comparisons that new knowledge of the dynamics of disclosure of domestic violence has been revealed. These findings are further discussed in section 4.3.

4.2 Postnatal disclosure of domestic violence and comparisons with disclosure within the first trimester of pregnancy

Five hundred postnatal women were invited to participate and a response rate of completion of the AAS of 44% (n=221) was achieved. Of the women who chose to respond, eighteen answered 'yes' to one or more of the questions asking about experiences of domestic violence. Of these eighteen women, eleven answered positively to 'have you ever been emotionally or physically abused by your partner or someone important to you'. Thirteen women answered 'yes' to 'in the year before they knew they were pregnant, had been hit, slapped, kicked or otherwise hurt by someone', whilst only four women out of the eighteen disclosed experiences of domestic violence during their recent pregnancy, of which three required hospital admission at some stage. Exploring the responses in more detail revealed only two women disclosing domestic violence at all three times in their life (i.e. ever been emotionally or physically abused, year before pregnancy and during pregnancy).

The postnatal data revealed that all the eighteen women who disclosed domestic violence at some stage in their life delivered at term (i.e. between 37 and 42 weeks), apart from one woman who delivered at 35 weeks. Five of the women were having a second or subsequent baby, whilst thirteen of them were first time mothers. Using a Chi Square Test, there was no statistically significant relationship with the independent variables of age, ethnicity or

employment status and the experience of domestic abuse ($p>0.05$). Starting to drink and smoke in pregnancy was found to be statistically significantly related to being abused women (Mann-Whitney Test, $z=-4.766$, $p<0.001$). The majority of the women who had reported domestic violence had been admitted to hospital at some stage during the pregnancy (67%, n=12). However, only three women reported being admitted into hospital as a direct result of violence. Infant feeding method was chosen by the woman herself (50%, n=9), or as a joint decision (44%, n=8), or solely by the partner (4%, n=1). Sixty seven percent (n=12) of babies were artificially fed whilst 33% (n=6) were breast fed. In one relationship the partner solely chose the infant feeding method himself, which was artificial feeding.

4.3 Comparing the data

This study focuses on disclosure of domestic violence in post pregnancy (i.e. early postnatal period, between 1 and 5 days post delivery) and compares these rates of disclosure to those of the first trimester of pregnancy. Three clinics accessed by women in the first trimester are identified as (a) Booking In Clinic (women booking in during a hospital visit with a midwife), (b) Early Pregnancy unit (women requiring medical observation or investigation), and (c) Pregnancy Counselling Clinic (women considering a termination of pregnancy).

When comparing the postnatal data to data gathered in the previous studies, the lifetime prevalence rates of disclosure of domestic violence were 7.3% (n=15) in Booking In Clinic, 26% (n=83) in Early Pregnancy unit, 35.1% (n=106) in Pregnancy Counselling Clinic and 8 % (n=11) in the postnatal period. A comparison of lifetime prevalence rates of domestic violence in clinics attended by women within the first trimester of pregnancy, and in the postnatal period, is presented in Figure 4.

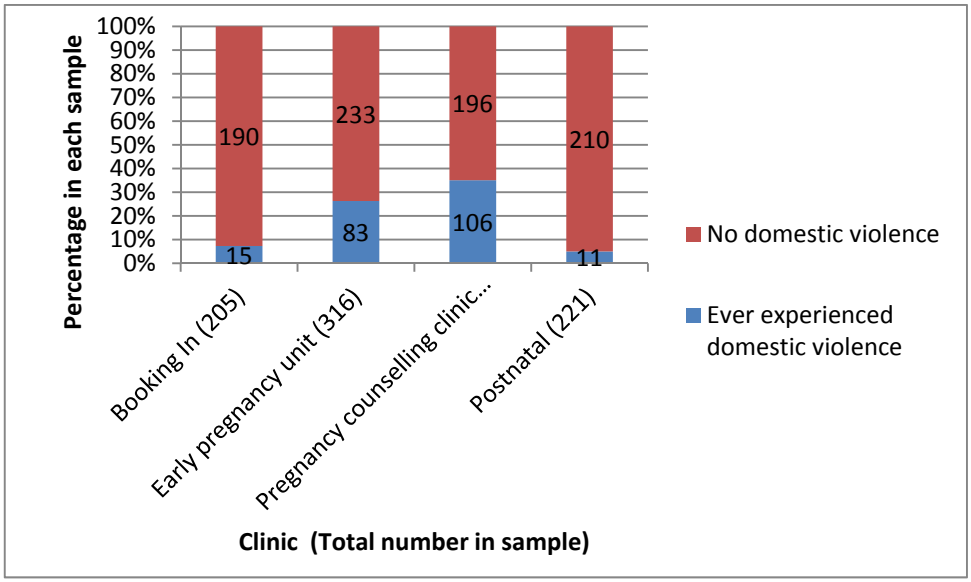


Figure 4: Comparison of lifetime prevalence rates of domestic violence in clinics attended by women in the first trimester of pregnancy, and in the postnatal period.

4.3.1 Actual physical abuse within the last year

The reported rates of domestic violence in the year before the women were pregnant revealed a different trajectory. The lower rates of domestic violence were evident within Booking In Clinic (2.4%; n=5), Early Pregnancy unit (8.5%; n=27), and also the immediate postnatal stage (5.8%; n=13), whilst higher prevalence rates remained in the Pregnancy Counselling Clinic sample (19.5%; n=59). Figure 5 demonstrates the self-reporting rates of domestic violence in the twelve months prior to pregnancy.

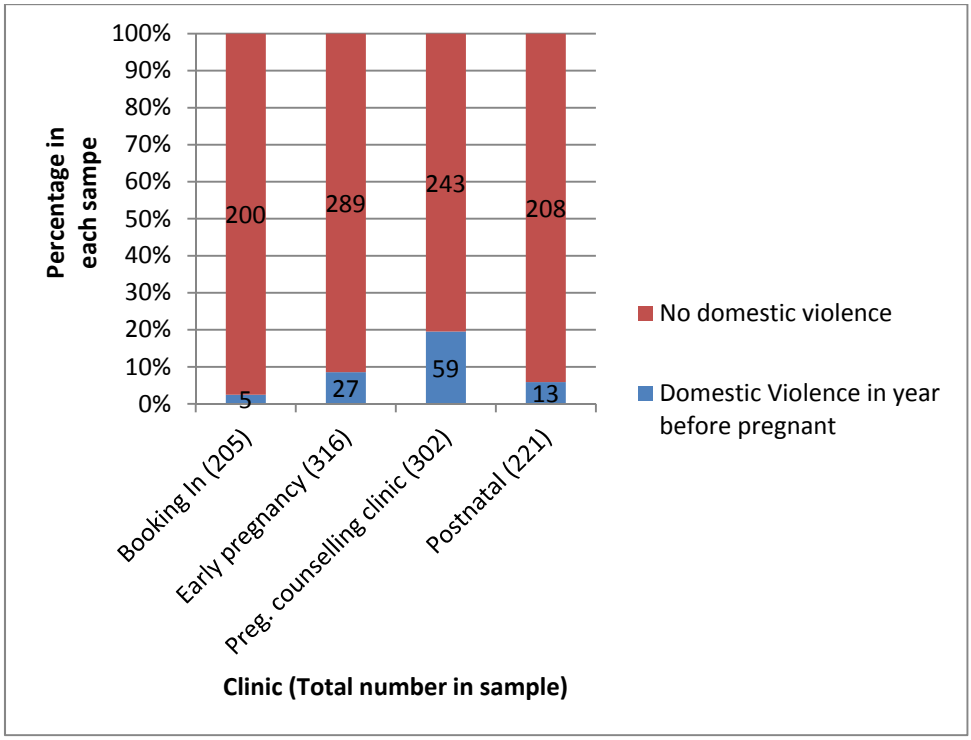


Figure 5: Comparison of prevalence rates of domestic violence experienced by women the year before they were pregnant.

4.4 Discussion

It is important to recognise the fact that the postnatal sample was not asked if they had experienced domestic violence in the postnatal period; rather, they were identifying if they had experienced violence before becoming pregnant and whilst pregnant. This, then, gives further meaning to the results as the samples provide a direct comparison of disclosure of domestic violence during pregnancy. By using the AAS they were asked about their experiences of violence from a lifetime perspective, and, in effect, also a retrospective view of domestic violence prior to and including that pregnancy. Therefore, it is interesting to note the disparity between the reported prevalence rates in this sample (i.e. women who had a baby) and the rates of violence reported in some clinics accessed by women during the first trimester of pregnancy, and also the data drawn from the general female population.

Figure 4 clearly indicates a difference in the lifetime disclosure rates of domestic violence by women within the first trimester of pregnancy. At the Booking In Clinic, 7.3% (n=15) of women reported violence. However, at the Early Pregnancy unit the disclosure rates soar to 26% (n=83) which is similar to previous published studies. Furthermore, in the Pregnancy Counselling Clinic the disclosure rates increase further to 35.1% (n=106); this, again, is a similar prevalence rate to previous published studies. Unwanted or unplanned pregnancies pose a three fold increase in the risk of physical violence over a planned pregnancy (Goodwin, et al., 2000; Pallitto & O'Campo, 2005). Undesired pregnancies may reflect sexual assault within an abusive relationship, thereby resulting in higher prevalence rates reported by women attending this clinic.

The reported rates of domestic violence in the year *before* the women were pregnant revealed a different trajectory and these are indicated in Figure 5. The rate of disclosure falls to 5.8% (n=13) when reporting from the immediate postnatal stage, which is similar to the prevalence rates of domestic violence demonstrated in the Booking In Clinic and Early Pregnancy unit, but significantly lower than rates reported in the sample drawn from the same population of women accessing the Pregnancy Counselling Clinic. Although previous studies have reported rates of domestic violence in pregnancy between 6% and 21%, (Campbell, et al., 2000), these are isolated studies.

The reporting rates of domestic violence from both lifetime and year before pregnant perspectives are consistently low from the Booking In Clinic and the postnatal sample. However, Early Pregnancy unit rates differ from 26% (n=83) lifetime experience to 8.5% (n=27) in the year before pregnancy, suggesting that women feel differently about disclosing domestic violence when the pregnancy appears to be viable.

Repetitive questioning about domestic violence may increase disclosure rates (Taket, et al., 2003). Six women in the postnatal sample had previously completed the AAS in another clinic within their first trimester of pregnancy. This, then, implies that there are a further number of hidden cases of domestic violence within the postnatal sample. It is not known how many women were asked more than once during their pregnancy.

In comparison, probability samples for the female population of childbearing age, regardless of their pregnancy status, have yielded prevalence rates of 15% (Gelles, 1990) and 20.5% (Jasinski, 2001). However, in this current study the population was drawn from the same geographical area, repeating the use of the data collection tool and statistical tests. Therefore, results from Early Pregnancy unit and Pregnancy Counselling Clinic suggest perhaps that women feel more willing to disclose domestic violence at some stages in their life more than others. However, Booking In and immediate postnatal responses suggest a more complex dynamic and this is the focus of the following discussion.

4.4.1 First trimester experiences

The sudden decrease in disclosure rates of domestic violence in the Booking In Clinic is difficult to explain. If they are accurate reports, then the decrease is significantly lower than the prevalence rates in the other clinics involved in this study. It is suggested that there may be a 'honeymoon' period for women when booking in for maternity care, or a 'fresh start' scenario with the rationalisation that a new baby may 'sort out' the problem of domestic violence. However, for women accessing the Early Pregnancy unit, the higher disclosure rates of lifetime experience of domestic violence may represent feelings of having 'nothing to lose' by disclosure. The sudden decrease by over a third (from 26% to 8.5%) when asked

about experiences of violence during the year before they were pregnant may reflect an internal realisation similar to that experienced in the Booking In Clinic, of the impending pregnancy representing a 'new start', and that this feeling negates the desire to report domestic violence within the emotional close proximity of this current pregnancy. The higher rates in Pregnancy Counselling Clinic may reflect feelings that the future looks bleak and that the situation is unlikely to change, reflecting for some women the sexual coercion or forced sex that resulted in a pregnancy. This realisation may also strengthen a woman's consideration of, or justification for, thoughts about termination of the pregnancy; however, without further data I cannot conclude on this.

4.4.2 Immediate postnatal period

It is extremely difficult to explain the sudden decrease in disclosure rates of domestic violence in the immediate postnatal period. It may be that there is an element of preoccupation following the arrival of the baby, or a self-belief that the abuse will stop. In this sense a type of 'honeymoon' phase might be apparent in which the abused woman may well feel that a new baby equals a 'new start' to the marriage/partnership, and in this optimistic mode she may well begin to minimise the previous violence (further explored in chapter five, section 5.3). Equally, it might be a reflection of the denial of domestic violence, seeing the relationship through 'rose tinted spectacles' and the 'starting afresh' with a new baby. However, women may also fear repeated domestic violence, but that fear is overshadowed by the repercussions of health care professionals being informed (this is further explored in chapter six, section 6.5.2). Once the abuse is reported to a professional, it may be viewed as 'in the system' and there is an impetus to do something about the abuse. The woman may well feel a loss of control, and be under threat indirectly from the professional involvement and directly via the abuser.

Chapter Five: Love hurts: Women's Narratives on the Transition from Love to Violence

5.1 Introduction

This chapter is the first of four which addresses the second aim of the study, focusing the research on the women themselves and hearing their untold stories of subjugation, coercion and violence.

The identity of the women participants remains anonymous. However a brief précis of their status at the time of meeting (see table 7) contextualises the excerpts.

Following the women's stories through the process of coercion, from the pre-violence beginning stage of a relationship through to the initial emergence of violence, this chapter reveals the coercive and controlling behaviours used by the perpetrators to engage and then subjugate women. When combined, these narratives extended beyond the speaker, representing powerful illustrations of subjugation, domination and threats. Much contemporary research on this public health and social issue revolves around the effects of domestic violence and the provision of support following victimisation. However, this chapter explores the very beginning of the relationship.

Table 7: Contextualising each woman's narrative

Pseudonym	Age	Number of children	Years in the abusive relationship	Place of residence at time of interview	Perpetrator	Relationship status at time of interview
Poppy	39	8	5	Own home	Partner	New relationship (non-abusive)
Lily	30	4	5	Own home	Partner	Happily married (non-abusive)
Rose	54	3	36	Refuge	Husband	Married to perpetrator
Marie	39	3	4	Refuge	Partner	Left partner to move into refuge. Children live with non-violent ex-husband
Rebecca	21	1	5	Own home	Partner	Living with fiancé
Scarlett	30	2	18 months	Refuge	Partner	Left partner to move into refuge
Sarah	21	3	5.5	Refuge	Ex-husband and also partner	Returning to ex-husband who has children living with him
Melanie	39	1	20	Refuge	Husband	Left husband to move into refuge
Vicky	29	1	2	Refuge	Husband	Left husband to move into refuge
Stacey	21	0	2	Refuge	Partner	Left partner to move into refuge

Pseudonym	Age	Number of children	Years in the abusive relationship	Place of residence at time of interview	Perpetrator	Relationship status at time of interview
Tulip	25	3	Not disclosed	Home	Partner	Injunction obtained against partner, who has now left the area
Daisy	25	1	2	Home	Partner	Left partner to move into refuge
Orange	41	4	19	Home	Husband	Left husband to move into refuge
Vyvyan	Not disclosed	Not disclosed	5	Home	Not disclosed	Left partner
Louise	25	1	Not disclosed	Refuge	Partner	Left partner to move into refuge

The women's narratives highlight the tactics used by perpetrators to successfully engage women within a relationship with the intention of exerting control and inflicting violence. Indeed, Raven (1993) theorised that coercion may require 'softening the target' (that is, the woman) or 'setting the stage'. In an attempt to illustrate this point, I have chosen a term that is commonly used in the child sexual abuse literature , that of 'grooming' (Kierkegaard, 2008), to describe the same process. Dutton and Goodman (2005) argue that without an appreciation of the many ways in which the 'stage has been set' to 'prime' or 'groom' the woman for coercion, recognising a coercive threat and understanding the woman's response to it may not be obvious.

The subtle erosion of self-esteem and autonomy are revealed, leading onto the exposition of violence. The voices of the women are heard through their narratives, revealing graphic

descriptions of physical violence. I have striven to give each woman a 'voice', whilst observing the similarities in the narratives. This might guide our understanding of the important aspects of relationship development that become the defining precursor to abusive relationships. To facilitate these initial findings, I continue the women's narratives from the grooming tactics employed by the perpetrators to ensure their continued subjugation and dominance, through to the emergence of violence, and consider how this process successfully negates the women's ability to leave the relationship.

5.2 Beginning of the relationship

Women rarely start a relationship knowing a man is violent. Although there are incidents of women becoming emotionally involved with incarcerated violent men, one could argue that they do not pose a danger to the woman at that time. Thus, the question of why women enter into violent relationships is less pertinent for the purposes of this chapter than how a woman becomes emotionally involved in a relationship with a man, and then embroiled within a cycle of violence. This is a complex question and worthy of exploration.

Indeed, one has to explore the narratives of the women to reveal their engagement within relationships in which the subtlety of control emerges. The key element within these relationships is the range of controlling and coercive behaviours by the perpetrator, thereby limiting the partner's autonomy and undermining her self-confidence (Harne & Radford, 2008). These methods of manipulation successfully dominate consecutive partners, and each relationship has the same outcome: control and intimate partner violence (Burgess et al., 2004). The women's narratives reveal the experiences of living with a man who intentionally manipulates the relationship in order to dominate and control her. The stories include the emergence of violence and how, by application of intentional exercise of power, he negates

the woman's ability to leave the relationship. The stories about how the women's relationships commenced and then became abusive with the emergence of actual physical violence are vivid and detailed. Silences within stories may relate to the depth of suffering (Charmaz, 1999).

The findings reveal the perpetrator's use of three influencing tactics in this early stage of relationship development, in order to engage or soften a woman into the relationship sufficiently, and to then abuse her without her leaving. The three tactics have been termed: 'feeling special' (tactic 1); 'feeling vulnerable' (tactic 2) and 'commitment' (tactic 3). Whilst it is recognised that some scenarios may be replicated in non-abusive relationships, the totality of the coercive tactics appear to comprise the initial stages of the perpetrator's grooming process, engaging the woman into the relationship, and then exploiting her, through which he exerts his controlling behaviour. The subtle erosion of self-esteem and autonomy are revealed which ultimately lead onto the exposition of physical violence.

5.2.1 Feeling special (Tactic 1)

To commit to a relationship, even within the preliminary stages of its development, two partners find an initial physical attraction to each other and may then choose to engage within a romantic situation (Glick, 1985). Within a relationship with a potential perpetrator of domestic violence, the man may manipulate his behaviour to ensure the woman feels special, of unique importance and affection to him. By his emphasis on his congeniality, the woman may gradually increase her depth of attachment and loyalty to the relationship. In extreme scenarios a woman may be made to feel like royalty, removed from the normality of life and all its associations, with feelings of being placed on a pedestal:

> My partner was a postman, he was nice when I first got with him and that, you know he treated me wonderfully like a princess and everything was great (Daisy, pg1, para 1).

> I met my partner and things were great, he treated me like a princess, you know everything was amazing (Stacey, pg 1, para 1)

> We went for the meal, I had never been for a meal, I had never been on a night out because I had lived like quite a quiet sheltered life and erm with having the children young I couldn't have that anyway (Lily, pg 1, para 2).

> We got together through friends (long silence) and when we first got together it was quite good really, he made me feel special and all that (Tulip, pg 1, para 4).

Daisy and Stacey's excerpts illuminate the special feelings associated with their partners. It is a specialness beyond their expectations, a feeling of being above their usual status, of being like royalty. These feeling of superiority are accompanied by feelings of power, the woman being placed at a higher order than her partner. Similarly, Lily talks of her new experience, a sophistication previously lacking in her life. The event was significant to Lily; she emphasises the fact of 'going out for a meal' twice in immediate succession, almost as if in wonder of the event. Whilst the tactics described above could be seen as cultural signifiers of romance, paradoxically, however, this process is an exercise of power by the perpetrator beginning a process designed to subjugate his partner. Through this stage of the grooming process, the perpetrator gains the trust of the woman parallel to paedophiles engaging

children for a specific purpose (Kierkegaard, 2008). In terms of Raven's (1992) elaboration on the theory of social power (French & Raven, 1959), the exercise of 'reward' power and 'referent' power by the perpetrator is evident. He is able to give the woman things she desires and gain her sense of approval. For example, the similar use of the word 'princess' in the women's narratives was unexpected, suggesting that it is a feeling that they perhaps have not experienced before, singling it out as unique event and a status that she welcomes.

5.2.2 Feeling vulnerable (Tactic 2)

Another aspect of the development of an abusive relationship is the disclosure of vulnerability by the woman, and indeed the literature reports exploiting vulnerability as one of the key ways that abusive men are able to coerce and control their partners (Dutton & Goodman, 2005). The language used by the women to describe their own vulnerabilities gives an interesting insight into the ways in which they reveal and share their own intensely personal past experiences and feelings with their partners, revealing a depth of trust already gained by the perpetrator at this early stage of the relationship. These vulnerabilities, once known, are later exploited by the perpetrator.

> I sat there really nervous at the table and he would be saying 'there's no need to be nervous' and he would pick his knife and fork up and bang it on the table, and I felt absolutely humiliated, and kept saying 'don't do that don't do that'. And I didn't know what cutlery to use and I had to wait for him to start eating… he asked for a house wine and they brought it in the carafe and he said 'when I order wine I want it in a bottle' you know that sort of being the big 'I am – look at me' and 'I can do this' and I think he did pick up on my vulnerability really (Lily, pg 1, para 2).

> I loved him that much and I just wanted to keep him because I had seven children I thought I would never meet anyone again and I would be on my own (Poppy, pg 2, para 1).

> Because with no-one there, family wise. When he was there, even with the violence you know what I mean, there was still someone here, a bit of company. He was my rock at the time because I had no one else… it was only like two weeks after me and him [ex-partner] split up I moved in with the current one you see so I was vulnerable (Daisy, pg 8, para 4).

> … and then I found out… that I was six months pregnant to the previous partner. Erm so my head was in a bit of a mess but there was a lot of problems with the baby so I had to have a termination… It was more forced by him you know because there could have been things they could have done for the baby (Stacey, pg 1, para 1).

What is apparent through all these stories is not just the sense of sharing personal vulnerabilities with their partners, but also the acceptance of the responses from their partners. There is no awareness of the risk they are taking in revealing these intrinsic vulnerabilities, signalling the significant trust already placed in the partner at this stage of their relationship. Indeed, through the grooming process the perpetrator has already succeeded in his coercion of the women, entrapping his victim into the relationship (Harne & Radford, 2008). The 'reward' power by the perpetrator is evident. He is able to give the woman things she desires (French & Raven, 1959). Reflecting on her experiences, Lily now recognises her vulnerability. Stacey's excerpt is similarly revealing, with paradoxical feelings

toward termination of her pregnancy by a previous partner, whilst embracing the thought of a pregnancy with this partner. Male coercive control through regulating women's fertility and pregnancy are identified in existing literature (Moore, et al., 2010).

5.2.3 Commitment (Tactic 3)

Abusive men often have high levels of interpersonal dependency (Gilchrist et al., 2003) which may manifest from the early development stages of a relationship. To facilitate this dependency by the woman, he may develop a number of strategies to ensure he appears to be the sole provider of social support and interaction for the woman, thus creating an emotional dependency upon him. These tactics may include pregnancy, suggesting the woman leaves her employment, or relocation. The growing emotional dependence of the woman is associated with the manipulation exerted by her partner to further control her. Dutton and Goodman (2005) suggest that when the emotional dependence in the relationship is unbalanced and extreme, the person who is less attached to the relationship has the greater power. However, irrespective of how emotional dependency develops, it can always be exploited by a coercive and abusive partner:

> I met him I think after about three or four months after my previous relationship and the first three months everything was okay. He asked me to move with him into his house so I moved. I used to go to work and I used to have friends and things like that (Marie, pg 1, para 7).

> He packed his job in when he moved in with me and he was living off me then. I have never had any money… he would get bits of food in, but the food he did get in was always like, not nice (Daisy, pg 7, para 3).

> He was like ‘oh we will have our own’ [baby] and ‘I want my first to be your first’ and this, that and the other (Stacey, pg 1, para 1).

> He came round and he just seemed like charming and ‘I can get you this’ and ‘I can do that’, and like he played really well with children. Erm, and I think he just didn't go home from then, he just stayed. And that was it, he never asked, there was no conversation about him moving in you know and I became like you know the little housewife who got up in the morning and I ironed his shirts and made his sandwiches, made sure he had eaten them, I just sort of stepped into that role (Lily, pg 1, para 2).

Within each narrative the individuality of the woman’s commitment to the relationship is clear. However there is also a commonality between them: the subtle manipulation by each woman’s partner. Although none of these narratives reveal a criminal offence, they are however part of the cycle of control; by living with the woman, he is able to potentially micromanage her day to day life, limit her autonomy and association with others (Harne & Radford, 2008), and enforce obedience and conformity. The sequential nature of social power (French & Raven, 1959), from the acceptance of ‘reward’ power through to the belief and the legitimising of the partner’s power, enhances the perpetrator’s subjugation of the woman through a range of coercive and controlling behaviours.

5.3 Emergence of violence

Once the woman has committed herself into the relationship, investing emotional labour and probably co-habiting with him, the perpetrator gradually increases his coercion through a variety of tactics. One of his forms of subjugation is through the use of threats and/or actual

physical violence. Coercive power (Raven, 1992), based on the woman's belief that she can and will experience negative consequences if she does not comply with the perpetrator's demands, is perhaps central to any theorising about coercive control in violent intimate relationships. Through the exercise of coercive power, the perpetrator creates the expectancy of negative consequences, an important way that Dutton & Goodman (2005) suggest 'sets' the stage or grooms women for coercion in relationships. As the emergence of violence begins within the relationship, the perpetrator exerts further control, and yet, at this early stage of the relationship, the women remain within the relationship, suggesting that her feelings of attachment for him override the need to leave the relationship, or point to the effects of coercive control in exploiting the woman, entrapping her in the violent relationship:

> I came back he was like, he kicked me and I said 'Why have you done that?' And he said 'I am sorry I'm sorry' and my leg had this big lump on it for weeks and he would be sorry and crying you know 'I'm really sorry'…and then leave it a few weeks and then smashing plates (Poppy, pg 2, para 2).

> So (pause) and after that [termination of pregnancy] things just went downhill calling me a murderer and all stuff like that, it was all psychological abuse and owning me basically. He started to get violent and controlling and taking my money and all that... The first two months were fine but then it was just horrendous. He would use weapons and stuff (long silence) (Stacey, pg 1, para 1).

> He started to get into drugs and drink which changed him to being a domestic violent person (Daisy, pg 1, para 1).

> I think it was three months later the first time that he hit me, he slapped me. I had never had anyone hit me before, had never had anyone hit me before, and I just stood and looked at him and then he just dropped to his knees and he said 'I'm sorry I'll never do that again' and 'I'm really sorry' and he begged and, I forgave him (Lily, pg 1, para 2).

> It started with alcohol when he was drinking when he tried to strangle me and all things like that and playing mind games, throwing me out in the middle of the night so I had to walk around the streets and things like that. And then he got worse and worse as he got, you know, drunk more alcohol (Orange, pg 1, para 7).

Daisy's excerpt clearly indicates what she considers to be the cause of the violence in her relationship: drink and drugs. Whilst the association between alcohol and male domestic violence perpetration has been well established (Kaysen, et al., 2007; Klostermann & False-Stewart, 2006; Lipsky, et al., 2005), alcohol itself is not a causative factor for domestic violence, though alcohol dependency increases the risk of violence (Jewkes, 2002). In contrast to Orange's experiences, the catalyst for the emerging violence within Stacey's relationship was termination of her pregnancy. Stacey's partner used the emotive reason of termination of pregnancy to commence the psychological abuse which often precedes physical assaults. Mullender's work has identified the damaging sequelae and interrelationships between psychological abuse, physical violence and sexual violence (1996).

5.4 Compliant subjugation

This part of the chapter moves from the initial emergence of violence to the subjugation of the woman, and the emergence of violence and associated subjugation evolve one from each other. Both these aspects of domestic violence within a relationship serve to represent the purpose of the perpetrators' tactics in both achieving domination of a woman and ensuring the dynamics of social power lie within the domain of the perpetrator (French & Raven, 1959).

This part of the chapter explores the women's journey through this abusive and controlling relationship pathway, using the women's narratives to reveal the processes, behaviours and attitudes exerted on them by their partners to continually dominate and threaten them, so much so that they feel unable to leave the abusive relationship. Domestic violence should be constructed as coercive control, with the range of behaviours constituting domestic violence as points on a continuum (Dobash & Dobash, 1992), and help with understanding the impact of coercive control on the liberty, autonomy and self-confidence of women. Indeed, subsequent sections of the chapter reveal the women's compliant subjugation, recognising that the intimidation and abuse negated any feelings of escape. The perpetrator ensured further subjugation through a myriad of behaviours leading to domination of the woman, whilst continuing to erode her autonomy and self-esteem. The women's stories reveal the interplay of psychological intimidation, sexual domination, and physical assaults by their partner for this purpose. Mullender's work (1996) highlights the impact of psychological abuse and, further, that it is often accompanied by physical and sexual violence which reinforces the perpetrator's control over the woman.

5.4.1 Feeling threatened

The threats directed against the women and their children are significant episodes in the women's lives, creating an environment of intense fear and acting as an inhibitory factor to disclosure. The psychological abuse of threats, 'mind games' and the use of children within these threats has clear negative effects on the women's decision making capabilities and lifestyles. Furthermore, the erosion of self-esteem and the removal of socialisation are implicit in the lack of contacts to share experiences, leading to further social isolation of the women. The resultant effect ensures that the perpetrator is the primary, possibly only, source of support for the woman, leaving her dependent upon him. Although there are many excerpts presented here, they are all clear, vivid stories of how each perpetrator has used social power to ensure his partner remains subjugated:

> He had threats that he would kill me; kill the children, erm, he would tell people that I'd been sleeping with people, erm, threats like towards my family (Lily, pg 10, para 2).

> He has said he is going to kill himself if I don't get back with him. He has threatened to kill me and the kids if I didn't get back with him and just loads (Tulip, pg 2, para 1).

> We were walking and got bundled in the car and took straight home and that's like why this time he's [ex-partner] saying he's saying he's getting the big boys in you know 'they will find you and this is the last time and they will do the job proper' (Melanie, pg 3, para 3).

> He told me if I didn't make a statement against the kid's dad saying that it was him that done all the bruises he would beat the hell out of my kids and I would be watching, and he would get a knife from the side and he said he would slash me to pieces. So I had to do a statement against the kid's dad (Sarah, pg 2, para 3).

> They [threats] are quite scary because he is capable of anything really so I couldn't say if he would or if he wouldn't do it. He threatened me with a knife when I had hold of my daughter. I think she was only two. He held a knife to my throat (Tulip, pg 5, para 4).

> I was always scared of him and I used to say to him I'm scared of you. He'd be working during the day and I would be off somewhere and if I didn't get a text I would be thinking there was something wrong. It's all going to happen when I go home. If we used to go out, because we worked in a working man's club we used to get home and the older ones were there they would whisper and say quick let's go upstairs because if he started I didn't want them to see it all. I would say 'can you go upstairs to make sure the others aren't awake, keep them quiet' (Poppy, pg 5, para 5).

The women are familiar with their male partner's behaviour, being able to recognise subtle changes that may be indicative of an impending attack. Poppy's narrative reveals her emotional acumen, the anticipation or premonition of an assault becomes clear due to her partners' behaviour. She reveals an intuitive knowing of an impending attack by her partner. The other women's excerpts reveal threats, a psychological intimidatory technique used by

the partner to continue subjugation. Jeremy Bentham's panopticon prison produces parallels to these women's behaviours: self-regulation as an act of compliance to the coercive control they are experiencing. As in the panopticon prison the ongoing exercise of coercive control requires only the creation of a belief that the threatened consequence will be delivered, not its actual delivery. This self-regulation is due to the women's belief that they are being watched by their perpetrator.

5.4.2 Sexual domination

This section of the chapter explores the use of sexual domination as a form of subjugation. Sexual violence represents a powerful gender specific domination and reinforces the perpetrator's control over the woman (Mullender, 1996). Exploiting his domination of the woman in this way, the perpetrator may force her to have sex or force participation in acts of sexual deviancy. It may be systematic abuse or random in its occurrence, often accompanying it with slanderous accusations and questioning of the woman's sexual integrity. These excerpts are evidence of the exploitation of previous traumas, and the continued subjugation and degradation of the woman:

> I can't say it [sexual assault] was every night (long silence) or it was every week (pause) it was just, I don't know, whenever he was feeling whatever he was feeling when he took it out on me or whatever (Rose, pg 2, para 2).

> ... and then in the bedroom it went (pause), when I was asleep he would start doing stuff and tying me up and stuff like that... when I was asleep he would start doing stuff, touching me and like (silence)... erm quite a bit yes ... [Rebecca visibly upset] I never reported it. I never said anything about it (silence) (Rebecca, pg 2, para 1).

> I was raped at five and my mum and stepdad left me with a babysitter and he raped me... and then my stepdad done it to me when I was like 12... and then at 14 or 15 I was raped again by someone I thought was my friend. I told Phil [ex-partner] all about that and then he has pretty much done a lot of that stuff... he has also tried to rape me while he had his mum sat in the car waiting for him. He climbed through my bedroom window while I was asleep and tried to rape me. He tried to make it out like it was all my fault, saying this wouldn't be happening if you just got back with me (long silence) (Tulip, pg 1, para 5; pg 2, paras 1 & 2).

> He used to make me watch porn movies and make me do stuff I didn't want to do. He forced me to do it and I would scream. He even tried pushing things up me but I would scream. I don't think I will ever be able to do anything again (Stacey, pg 5, para 3).

Sexual coercion within intimate relationships is often motivated by control and domination (Gage & Hutchinson, 2006). Kelly (1988) includes rape and a range of humiliating, unwanted, pressured and coercive sex acts within this context of sexual coercion within domestic violence. These excerpts reveal a depth of suffering following sexual assault within the relationship, revealing rape and acts of sexual deviancy. The most difficult part of their story to narrate, many of the women refer to sexual abuse in an abstract way, not revealing any depth of experience and changing the course of narration rapidly. The difficulties within the language of rape, and the perception of what rape constitutes, results in experiences of sexual violence being one of the most emotionally challenging to verbalise (Harne & Radford, 2008). The silences within these narratives are revealing in themselves. Silence does

not only refer to an absence of subject matter to share, but also a defining moment in which the narrator (Rebecca) reflects on her depth of suffering and reclaims the power from these experiences (Charmaz, 1999). These narrations are incomplete with evidence of both hesitancy of recollection and verbalising the traumatic experiences. The subjugation of the women is extended through sexual exploitation, with the women narrating stories of the perpetrators' intentional use of his knowledge of his partner's experiences of abuse in former years to repeat the offence, thereby re-traumatising whilst simultaneously dominating the woman physically, sexually and emotionally.

5.4.3 Being hurt

Sustained physical assault is another form of subjugation and this type of abuse is perhaps the one that is most often associated with the term 'domestic violence'. Following the initial emergence of violence within the relationship, the subjugation is maintained through an escalation of inappropriate behaviours inflicted by the partner as he continues to erode the woman's confidence and self-esteem. The violence may escalate to a near death experience for the woman, requiring urgent medical assistance. The next chapter (chapter six) explores the experiences of the women in negotiating access to the health care system following domestic violence, including during the pregnancy/childbirth continuum. However, in this section the women talk of their experiences within their relationship, of being hurt by their partners:

> He was hitting me with his golf club and there was blood everywhere, like off my hand and everything and he spilt my head open as well so there was just blood everywhere. There was blood all over his hands and he just wiped it all over his face. I just have this picture and it knocks me sick because he wiped the blood all over his face, all over his arms, all over his

top and he just had his tongue hanging out and he was like licking the blood off his hands laughing. I don't know why he did it and I just looked at him and thought he is going to fucking kill me now (silence) I just thought I was going to die (Stacey, pg 4, para 1).

He used to punch me, kick me, smashed plates, at one point he had a plastic bag over my head and tried to suffocate me. He has had his hands round my throat trying to choke me, he has picked a bed up and threw it over the top of me (Daisy, pg 1, para 3).

Ended up me having black eyes because of his rage, his temper just came out and started hitting out again… I've always had bruises where people couldn't see it, erm, but I remember having my son, two days after I had him... I couldn't find his keys you know the keys weren't to hand I got slapped, I got punched, I got pulled down to the floor by my hair, I was kicked about 7 or 8 times and then I just got told to get up and get out to the car (Lily, pg 3, para 1).

He [partner] went and cut the arm of the kid's dad and because we had been sleeping together, we had been in bed and the next thing was I was in the bedroom, and he went and took the knife up to the kids dad's throat and I told him 'no don't' and everything, and he said he wanted to talk to me, so I got dressed and I said to him 'come on, if I talk to you will you leave him?' And he said 'yes'. I went outside and he grabbed out hold of my face here

> [points to jaw] and put the knife to the other side and he said he was going to slice me from my neck to my back (Sarah, pg 2, para 5).

> And he just starts like slapping me, grabbing me by the neck trying to put me through the window you know the window in the flat and I tried to grab him and push him away. That day I thought he was going to throw me out of the window. I was panicking and with his cousin as well he started slapping me around and hitting me and kicking me and everything, he pulled my hair, bite me on the head and everything and I was proper nervous (Marie, pg 3, para 3).

> Usually when he hits me it is in place that I wouldn't bruise so, so they still wouldn't know had been hit because I couldn't say there's this one that you did and that one that you did, no one would notice... sometimes they could go year between beatings and other times it was every few days so it was never constant (Melanie, pg 2, para 4).

These women provide clear and vivid descriptions of significant episodes of violence they have experienced, inflicted by their partners, thus demonstrating the physical power gained by the perpetrator to control his female partner. Power is dynamic and, as such, the perpetrator is able to change his methods to exert different power bases to subjugate his female partner (Raven, 1992). Coercive power is based on the woman's belief that she can and will experience negative consequences if she does not comply with the perpetrator's demands. However, this chapter moves on from this point to the actuality of physical violence. The women's stories reveal the depth of subjugation through a process of coercion,

in which women remain in a relationship despite experiencing considerable injury. Moreover, the use of coercive control by men in violent intimate relationships is a process (Stark, 2007) rather than an act (Johnson, 2005), and has been likened to the techniques of 'coerced persuasion' used on prisoners of war and the conditioning to prostitution of women by pimps (Okun, 1986). Indeed, like prisoners, these women are hurt and injured against their will and kept 'prisoners' within their own home. Stacey talks of her injuries, repeating 'blood' as if emphasising the amount visible. It was the event that led her to escape her involuntary confinement within the flat she shared with her partner, the final act of violence. *I just thought I was going to die* suggests that Stacey has ascribed this specific event as a premonition of impending death, the moment of finality. Although several excerpts are presented here, each one represents a significant event in the women's lives. Daisy and Lily's narratives reveal the multiplicity of their experiences of abuse, the events so intertwined that separation of each act of abuse or violence is not possible. Melanie reveals the threat of death from her partner next time she is found. She speaks pragmatically about this, perhaps due to resilience to threats from living with her partner for twenty years or an acceptance of this eventuality.

5.5 Discussion

Exploring the early development of a relationship in which a man engages a woman with the intention of exerting abuse, including physical violence and controlling behaviours to entrap her, the women's narratives reveal a process of softening her, setting the scene (Dutton & Goodman, 2005) or grooming (Craven, Brown, & Gilchrist, 2006). Paedophiles use a similar process of grooming to desensitise children in order to prepare and then trick them into accepting sexual abuse (Craven, et al., 2006). The women's narratives in this study identify

similar tactics to the grooming process employed by their male partners with the intention of preparing the woman for compliance, including being physically hurt.

Within the context of a relationship in which domestic violence exists, the initial stage of this grooming process commences with a perpetrator treating her with the utmost respect and showering her with love so she feels she is special. This appears to facilitate the woman in experiencing subtle feelings of power, of being superior to him, and of being cherished. This tactic appears to be *the* key element of coercive control for the women in this study, used deliberately by their partners to engage the women in the relationship with the intention of abuse through coercive control. The timing of this also appears to be critical, as according to Briñol women's feelings validate their existing attitudes because they have occurred at the commencement of the relationship, before the woman becomes conscious of the controlling motive underpinning the perpetrator's behaviour (Briñol, Petty, Valle, Rucker, & Becerra, 2007). Once the woman has internalised this status, the power balance has been gradually eroded through a sequence of coercive and controlling behaviours, leading to a desensitisation to his increasing expectations and demands. Domestic violence as 'control' provided the theoretical foundations for the development by the Domestic Abuse Intervention Project (DAIP) in Duluth, Minnesota, of the Power and Control Wheel and the Duluth model of perpetrator treatment (Pence & Paymar, 1993). The Power and Control Wheel describes a number of interrelated control tactics that Stark (2007) has subsumed under four headings: violence, intimidation, isolation and control – tactics that Schneider (2000) refers to as the 'generality' of coercive control. Indeed, the exploitation of women's vulnerability is located along the continuum of an abusive relationship. The narratives presented in this chapter build on Stark's (2007) work, identifying the precursor to the coercive and intimidatory behaviour, the 'feeling special' stage of the relationship (see section 5.2.1). Subsequent to this stage, the

partner attempts to strengthen the woman's emotional attachment to him by isolating her from family and friends. This additionally contributes to the gradual reversal of the power balance within the relationship, resulting in the perpetrator being able to exercise greater power.

Recent research studies have identified individual and societal vulnerability factors related to domestic violence (Crandall, Nathens, Kernic, Holt, & Rivara, 2004). However, the presence of these factors does not always result in a relationship becoming abusive; rather, they raise the potential risk of a woman becoming involved in an abusive relationship. It should be acknowledged that the cause of abuse within a relationship is the conscious decision by a perpetrator to perform or engage with controlling behaviour directed against his partner. The emergence of a physically violent act appears early within a developing relationship, often accompanied by an apology or a gift. The depth of manipulation and control within these relationships is revealing because, as disclosed through the women's narratives, this act does not usually result in the women leaving the abuser, even at this early stage in the relationship. This is suggestive of a strong emotional attachment developed – perhaps encouraged – by the perpetrator in the early stages of the relationship, through which he exerts control.

For some women the initial physical assault would result in the immediate withdrawal from the relationship. However, the women in this study remained in the relationships, suggesting that they felt unable to leave. Pence and Paymar (1993) emphasise that although domestic violence has several forms, it is the physical and sexual violence or credible threat of this violence that provides the matrix on which to develop the other forms of domestic violence. Indeed, the women's narratives reveal the inter-connectedness of physical violence and the

myriad of controlling behaviours adopted by a male partner ensuring the subjugation of the woman and using a variety of tactics. The silences within the women's narratives hint at the extent of their suffering, with some experiences being too traumatic to disclose. The excerpts from each woman's story reveal the perpetrator's coercive tactics through which he successfully erodes her self-esteem and autonomy.

The findings from this study reveal new and useful information that may help women recognise a pattern of behaviour indicative of the grooming process employed by a perpetrator of domestic violence. They point to a distinct pattern of behaviour by a perpetrator. The similarities in the narratives may guide our understanding of the important aspects of relationship development that might become the critical factor in abusive relationships. Thus, perhaps through embedding this knowledge within educational programmes, further abusive relationships may be prevented or recognised as such at an earlier stage.

Chapter Six: Women's Negotiation of Health Care following Domestic Violence

6.1 Introduction

Chapter four revealed that women in specific periods of gestation may choose to withhold disclosure of domestic violence when accessing clinics within a hospital environment. Exploring the social response to domestic violence, this chapter focuses on the second aim of the study by returning to the theme of the health service and exploring the women's stories, revealing their interactions with health care provision whilst living with a coercive and violent partner. Hartsock (1987) suggests that when caring for others our knowing will yield more valuable representations than when informed by the interests of domination. Brooks and Hesse-Biber (2007: 4) argue that, 'By documenting women's lives, experiences, and concerns, illuminating gender-based stereotypes and biases, and unearthing women's subjugated knowledge, feminist research challenges the basic structures and ideologies that oppress women'. It is argued within this chapter that the acquiescent approach of the health service to violence against women by an intimate partner serves to reinforce the subjugation of the woman. Supporting the claim that women offer a unique nature of knowledge derived from their personal and social experiences, standpoint feminism provides a framework through which to give voice to women during pregnancy and childbirth, these being uniquely female experiences.

Chapter five explored the process of grooming a woman into a relationship through a subtle process of subjugation and the use of coercive tactics, thus presenting a deeper understanding of the dynamics of how women become engaged within a relationship in which domestic violence features. The effects of these tactics of coercion used by perpetrators in this role

were also explored. This, then, provides a backdrop for chapters 6, 7 and 8 which explore the women's experiences of seeking help from statutory agencies. This chapter reveals the interaction between the women and access to the health care system. The next chapter (chapter 7) reveals women's experiences of social worker interventions; whist chapter eight reveals the interaction between women disclosing domestic violence and the first response police officer.

Following the emergence of violence within a relationship, physical and psychological injuries may necessitate a woman's access to health care services. Previous studies have indicated that women are more likely than men to experience negative responses to health complaints (Walby & Mayhill, 2004), which may consequently reduce women's opportunities to disclose and thus escape their violent relationship when accessing health care. Additionally, despite these negative health sequelae, women may choose to remain within the violent relationship and refrain from disclosure of the abuse (O'Campo, et al., 2008). This issue will be addressed in section 6.2. This chapter then explores the women's negotiation of accessing the health care system itself, and the results of that negotiation (section 6.3). Theorising domestic violence from a feminist standpoint, it is argued that it is this standpoint that is critical to the understanding of the oppressive systems in society, such as the health care system. The women's stories reveal the reactions of health care professionals to them when they either actively disclose violence, or when there is suspicion of the occurrence of domestic violence. The health service responses are indicative of the oppression through acquiescence to domestic violence (section 6.4). Furthermore, it is argued that pregnancy and childbirth pose a unique risk to mother and baby, being a critical time for domestic violence to commence or escalate.

Thus, the second part of the chapter (section 6.5) explores the women's experiences of domestic violence during their journey through pregnancy and childbirth. The women talk of their experiences of physical violence during pregnancy (section 6.5.1). Returning to the phenomenon identified in chapter four, of women refraining from disclosing their experiences of domestic violence at specific points along the pregnancy/childbirth continuum, the subsequent sections of this chapter explore the women's stories on their decision to conceal domestic violence from health care professionals (section 6.5.2), and also the underpinning emotions that contributed to the decision making process of infant feeding (section 6.5.3).

Symbolically, the final part of this chapter (section 6.6) explores the women asking for help, at a time of either leaving the relationship or after leaving, this being the end stage of their relationship with that partner.

6.2 Silent screams

Despite the necessity of health care intervention following some experiences of domestic violence, many women remain silent. However, this silence is not through an absence of words; it is argued that this is a 'silent scream'. This section explores the women's reluctance to vocalise their experiences of domestic violence to professionals when accessing heath care. The women have developed a 'silence' in response to their partner's threatening behaviours, a fear surrounding disclosure of their experiences of domestic violence, revealed in their stories:

> I went to the doctors and they never even clicked on, because I was feeling low, so I went to the doctors and they asked where the bruises came from

> but I couldn't tell them and they said nothing else about it (Rebecca, pg 2, para 8).

> No one asked me about any abuse no one has ever asked me ever even having the three kids no-one has never ever asked me. I went to see the nurse at doctors at the health centre she wasn't any use. I told her like erm, I was depressed… Erm, she wasn't very useful at all because she just turned round, well, she wasn't really interested (Orange, pg 5, para 2).

> The receptionist got me to see the doctor but he [partner] caught up with me by then so he had to come in with me and I was trying to get a reaction [from the doctor] and like leaning back so he [husband] couldn't see me (Melanie, pg 1, para 1).

Only a minority of survivors of domestic violence are identified by health professionals (Feder, et al., 2006), resulting in the majority enduring further abuse with an absence of support. Moreover, women present to doctors with a variety of complaints without disclosing the underpinning experiences of domestic violence (Hegarty & Hindmarsh, 2000). However, women remain reluctant to disclose the violence in what Foucault (1980) argues is a resistance to the caring enquiry of nurses' despite their authority and afforded power. Contrary to these silences being a 'learned helplessness' (Stewart & Cucutti, 1993), it appears that they are located as a self-preservation tactic. The silences are a chosen behaviour of self-protection, the women using past experiences of sustaining their silence surrounding domestic violence, paradoxically, to maintain aspects of their safety. Indeed, within the development of the relationship the silence is valued more than voicing their fears (Taylor,

Gilligan, & Sullivan, 1995). Siddiqui & Patel (2003) suggest that when remaining within the violent relationship, women develop coping strategies to promote their own safety. This silence may pivot on a fear of disclosure or intuitive concern when accessing health care, and may arise from fears of the perpetrator discovering disclosure or the anticipated involvement of other agencies such as social services (see chapter seven, section 7.3). Furthermore, Hegarty and Taft (2009) highlight the existence of women's internal barriers to disclosure, as women perceive the problem of domestic violence as their own. For a woman to be alert to the consequences of her actions in this way, feminist standpoint theorists argue that this emotional acuity is a unique and intuitive ability to interpret consequential actions through intuition (Jagger, 1997). In part, this is the resultant effect of living within a relationship in which the power and coercive tactics used by the perpetrator enforces subjugation (see chapter five).

Whilst these are to be considered, it is evident that a plethora of other factors affect disclosure of domestic violence to health care professionals. These include the provision of a safe and confidential arena, and being non-judgmental and caring (Battaglia, et al., 2003). Feder at el (2006) argue that a woman's decision to disclose is affected by the way she feels about her experiences, the health professional needing to confirm the violence as unacceptable. Although in these excerpts, their experiences remained hidden, throughout the other excerpts in this chapter there are examples of the women 'leading' the health professional to initiate dialogue about their injuries. The onus on disclosure appears to be located within the heath care professional's domain, to recognise the women's injuries as being related to domestic violence and thus acknowledge them as such.

6.3 Negotiation of access to health care

The negative health sequalae of domestic violence includes physical and psychological injuries which often require medical attention. However, due to the nature of the relationships in which domestic violence features, subjugated woman may be denied autonomy and therefore the perpetrator may inhibit access to medical care. If he has caused the injury and medical attention is essential, his close accompaniment of the woman negates her ability to disclose abuse to health care personnel. The following excerpts from the women's stories reveal the negotiation of access to health care:

> He locked me in, he didn't let me out for the last two months I was with him because we lived in a block of flats on the 11th floor so there was no way out and he stabbed my hand there [points to 2" scar on side of hand] and started showing it to all his mates buzzing off it because it was a big massive wound. I couldn't go to hospital or anything, he wouldn't let me (Stacey, pg 1 para 2).

> So I tried pushing my way out and the just used to push me back and say 'if you ever leave me I will punch the baby out of you'. So then he jumped on me and I was like 'I need an ambulance, I need an ambulance!' (Rebecca, pg 4, para 2).

> I have had my eyes checked because he has given me loads of black eyes, it was like getting my vision checked after them but I have always said that I have walked into a wall or something has happened or I have been going to a boxing group you see, I used to say I was into boxing and erm I was fighting in the ring and that is what happened (Daisy, pg 1, para 4).

By living with the woman, the perpetrator has been able to micromanage her daily existence, limiting her autonomy and association with others (Harne & Radford, 2008), including accessing health care. Furthermore, as revealed in these excerpts, he enforces obedience, displayed through the concealment of her injuries or concealment of the causative factors of her injuries. Stacey talks of the absence of medical care due to her partner's obstruction. Dutton & Goodman (2005) suggest that the perpetrator has already created an anticipation of being hurt, as part of the process of coercion, and these narratives reveal the actuality of this violence. Rebecca and Stacey negotiate access to health care provision as a direct result of injury. Despite this no health based intervention took place, and thus they returned to the violent relationship.

6.4 Being asked about domestic violence

The notion of routine enquiry of domestic violence for women accessing medical care has been the subject of much debate. The efficacy of this method of enquiry to improve disclosure rates of domestic violence and the outcomes of it are documented in the literature (Feder, et al., 2006). The focus of contemporary research lies within the health service personnel and the reasons for *them* not wanting to enquire about domestic violence. However, this chapter shifts the focus somewhat, exploring the effects of this reluctance to ask about domestic violence, through the lives of the women. The following excerpts reveal the women's experiences of either not being asked or being spurned in their attempts to disclose:

> They asked me in hospital, I think I got took in for something, I had a bruise on my neck there and I had bruises on my legs as well and then asked me where they were from and I just started saying things. And they turned round and said 'you don't deserve that' and stuff and that was it. It

> wasn't mentioned again... I think when you're pregnant you are more basically; your emotions are going everywhere so I think that is a bit of a dodgy time to ask (Sarah, pg 4, para 2).

> I told her [nurse] that was why I was like a bag of nerves and I was depressed because of him but she never did anything, and that was it! (Orange, pg 5, para 2).

> No, no, no one asked. They always just asked was a pregnancy okay and how were things, that was it really. Just normal general questions they asked. But no they never asked anything like that [about abuse] (Tulip, pg 4, para 4).

> I have never known them to ask, especially A&E. I have never known them to ask you know to separate them from the husband and say you know has he done this to you? I have never known that. I think because they're busy it is easier not to ask or even if they say 'no' not to push it. I don't think it very often gets asked (Vyvyan, pg 7, para 2).

Sarah and Orange both vocalise their experiences of domestic violence to the attending health care provider. This disclosure then impacts on the relationship between the women and their health care provider, re-negotiating it within the new post disclosure context and altering the power balance within it (Livesey, 2002a). Recommendation No.9 of the Department of Health (DH) recent document 'Responding to violence against women and children – the role of the NHS' states that 'women and children disclosing violence or abuse should feel assured

that their information will be treated appropriately' (Department of Health, 2010c: 6). Sarah and Orange's verbal disclosure is briefly acknowledged by the health care provider, but then the provider refrains from further discussion, this inaction failing to validate the women's experiences. There is a plethora of evidence substantiating claims that health care professionals do not want to ask about domestic violence, rotating around issues including lack of awareness and midwives' personal experiences of domestic violence (Mezey, et al., 2004). However, not asking women about domestic violence is suggestive of a societal preference for ignoring the problem. Even when the health providers' care for a woman presenting with injuries suggestive of domestic violence, their priorities appear to be the provision of health care, rather than listening to the woman's voice. Tulip and Vyvyan talk of the lack of enquiry. Despite the known deleterious effects on pregnancy (El-Kady, et al., 2005), this enquiry remains omitted from practice. Dutton and Goodman (2005) suggest that when the emotional dependence in a relationship is unbalanced and extreme, the person who is less attached to the relationship has the greater power. The nexus of power lies with the heath care provider as they are less attached. Foucault (1982: 208) argues that 'power relations are rooted deep in the social nexus', and that powers can be overlaid from one member of society to another, resulting in mechanisms of power that serve to silence the other. The excerpts presented here reveal behaviours suggestive of a hierarchy of domination and control within the health service, through which women's experiences are either ignored or negated, techniques that align with those of a perpetrator.

Furthermore, the women's stories expose the ways the health service, particularly midwifery care, functions as a medical model. This model has created considerable power and prestige to the medical profession (Foucault, 1982), in what Fisher (1997) argues is a form of medical neoliberalism, ensuring service users become consumers of health services. Thus, the focus

then shifts and the consumers become accountable for their own choices and which services they access.

6.5 Gestational experiences

This section of the chapter explores the women's experiences of their interactions with health care professionals at different stages of the pregnancy-childbirth continuum. Building on the new knowledge presented in chapter four, this section attempts to add to this body of knowledge regarding the reluctance of women to disclose domestic violence during pregnancy and in the postnatal period. The women's narratives reveal the emotional complexities following childbirth and their feelings towards disclosing an abusive relationship at this time.

6.5.1 Physical violence in pregnancy

Pregnancy may, for some women, be a period in their lives in which domestic violence begins or escalates (RCOG, 2001). The emergence of violence within the relationship has been explored in chapter five. However, these narratives reveal the violence within a specific period of time, during pregnancy. This violence has a causative effect on two lives, the mother and the fetus.

> I have lost two children previously at three months but he was violent to me when I lost those as well. But now my cervix doesn't shut properly because like I went through so much violence, so, that's why my cervix doesn't shut so I had to have the stitch in and everything (Rebecca, pg 4, para 3).

> My mum died… and I were pregnant and two days after she died he did a rocky on me, right on my stomach when I was pregnant hitting either side and ended up the baby died and I had to have it removed (pause) I was 16 weeks (Melanie, pg 2, para 3).

> There was a time when I was pregnant with my daughter when he threw, you know those big bottles of juice, he threw one of those at me, he threw cups at me, hit me in the face with a remote, he's flicked ciggies at me and erm he has dragged me out of the bathroom by my hair. He hit me in the tummy once when he just walked past me and elbowed me (Tulip, pg 3, para 7).

> When I was six months' pregnant, the beating me up, that was the worst because it got to the point where I thought 'I can't let him do this when I have a child inside me'... you know I thought what if I stay here, he is going to end up delivering the baby you know what I mean. He would say I need a Caesarean and cut me open and stuff. Something sick like that (Stacey, pg 3, para 1).

Pregnancy is a particularly high risk life event for women experiencing domestic violence with some suggesting that actual physical violence may be initiated or escalate at this time (Amaro, et al., 1990; McGee, 2000). During the antenatal and postpartum periods the violence may commence or worsen (Garcia-Moreno, et al., 2006), and this violence then poses a significant threat to the health and wellbeing of both the woman and her unborn child, adversely affecting the outcome of the pregnancy (El-Kady, et al., 2005) with an increased

risk of significant morbidity or death. Additionally, the coercive tactics of the perpetrator, as discussed in the previous chapter, prevent women attending antenatal appointments (Harne & Radford, 2008) further endangering the health of the woman and fetus through lack of health care. All these women talk of their experiences and the effects on the pregnancy, with two women (Rebecca and Melanie) experiencing miscarriages following domestic violence. Their narratives are uniquely female, providing a standpoint from which to explore the gendered effects of male to female domestic abuse during pregnancy.

6.5.2 The veil of secrecy

Surrounding many women's experiences of domestic violence is a veil of secrecy, a chosen silence by which the women hide their injuries from view. Some of these issues have been explored earlier in this chapter (see section 6.2) with the women talking about how they remained silent when accessing the health care system. This section, however, lies within the domain of pregnancy and childbirth, and contributes to the knowledge presented in chapter four that women in two specific periods on the pregnancy/childbirth continuum were less likely to disclose domestic violence. A unique life event, the woman's social and personal circumstances change with childbirth, as she metamorphoses from a woman to a mother. Thus, this veil of silence during pregnancy and childbirth is explored through the women's narratives from this unique perspective:

> I think it's just because they like they're [mothers] dead protective and they've got a bundle and they don't want no one coming in to say you're being hit and we are going to take it away don't know that that's probably it. Or maybe it's just that you want to be a little family and everything. I wouldn't have said anything (Melanie, pg 4, para 5).

> I didn't tell them anything because I tried to make out that life was a lot better than where I was staying beforehand (Lily, pg 2, para 1).

> I had the baby in hospital and he would come up to the hospital and kick-off at me but without anyone else seeing it. Just like you know when you have the curtains that pull round, well he would pull them around and sit there at the side of the bed and have a go not loud enough for anyone to hear but loud enough for me to hear... (Sarah, pg 1, para 7).

There are several reasons for a woman to employ a veil of secrecy when experiencing domestic violence. Melanie's rationale for this veil of silence during pregnancy and childbirth includes the risk of losing custody of the baby, but also the desire to be a 'little family' (pg 4, para 5, line 3). This resonates with the results detailed in chapter 4, section 4.5.2 in which women in the immediate postnatal period did not disclose domestic violence. Lily and Sarah reveal the ease with which they concealed their injuries from health care professionals, even though Sarah's experiences of domestic violence remained unabated whilst in hospital. This further endorses the position of the health service as an acquiescent partner in domestic violence. The Royal College of Midwives' 'Position paper' advocates recognition of domestic violence, documentation of it, and giving women information to make their own choice (Royal College of Midwives, 1999). However, Aston (2004) argues that midwives usually do not raise the subject of domestic violence, and women often feel silenced and unable to talk about it with their midwife. Women living with a perpetrator of domestic violence may be denied their autonomy, and thus the partner makes the decisions. As such the issue of self-disclosing domestic violence during the gestational period is complex. Some authors suggest that the absence of a strategic screening programme for women has a

negative effect on disclosure (Edin & Hogberg, 2002; Shadigian & Bauer, 2004). To encourage women to disclose abuse when accessing the health care system during the pregnancy/childbirth continuum, a conducive environment is necessary. Research has suggested that women are more likely to disclose to their family doctor in primary health care, rather than Accident and Emergency Departments (McKie, et al., 2002). However, repetitive questioning about domestic violence may increase disclosure rates (Taket, et al., 2003). The plethora of evidence citing reasons for non-disclosure includes the provision of a safe and confidential arena, and being non-judgmental and caring (Battaglia, et al., 2003). Feder et al (2006) revealed that a woman's decision to disclose was affected by the way the woman felt about her experiences, in that the health professional was required to confirm the violence was unacceptable.

6.5.3 How women feel about breastfeeding their baby

Chapter four presented results from the quantitative study which explored the prevalence rates of self-reporting of domestic violence. Data was also captured on the decision making of infant feeding (see section 4.3). That study revealed that for those women who disclosed domestic violence, the infant feeding method was chosen by nine of them, for eight women it was a joint decision between the woman and her partner, and for one woman her partner chose the infant feeding method. The narrative interviews with the women in the second study reveal some of their experiences which may underpin this decision making process.

> I was breastfeeding he would want to eat, he was like 'go and do me something to eat' and I'd say 'I can't I am breastfeeding the baby'. 'Stop it hey, she has had time to eat, she is eating all the time, she's eating every three hours, it's going to be fat' and I would say 'I don't care, she wants a bit of feed so I will feed her'. And (pause) there was a time when he

> grabbed me by the hair when I had the baby, I had the baby in my arms and he grabbed me by the hair and he pulled me to the kitchen with the baby in my arms but I couldn't leave the baby. I was crying my eyes out and I was thinking I can't do this but I was too scared to go away (Marie, pg 7, para 1).

> I breastfed them at first but then went on to the bottle. But when I had my youngest and I was breastfeeding him... he [partner] would bugger off out and leave me to it...he didn't really like it. I think he felt a bit jealous. I don't know why but I think he did. Because at one point I ended up having to express because he wanted me to (Tulip, pg 4, paras 1 & 2).

> I didn't want to breastfeed because I had to cover up (Rebecca, pg 12, para 6).

> He used to grab my breasts, he used to grope me and pull my breast all the time. Every time we sat down he would do it. So I feel they are dirty now and I can't even think about breastfeeding (Stacey, pg 5, para 2).

A subject of some controversy in feminism, breasts represent different meanings to different genders (Daniluk, 2003). Indeed, biology is not free from values (Lewontin, Rose, & Kamin, 1984), it is underpinned with arguments, assumptions and prejudices (Gunew, 1990). Van Esterik (2004) argues that breastfeeding is a feminist issue of importance to women as a source of empowerment and also contributes to gender equality, confirming the woman as having power over her own body. Furthermore, a breastfeeding woman challenges the media

model of the symbolism of breasts as sex objects (Van Esterik, 2004). The narratives in this section of the chapter reveal two influencing themes negating the woman's desire or ability to breastfeed her baby, thereby revealing the gendered nature of domestic violence and its impact on infant feeding. Both Tulip and Marie were unsupported in their breastfeeding, leading to discontinuation of this method of infant feeding. Marie's partner withheld support and intervened with the feeding process with the use of physical violence.

6.5.4 Women's perception towards their bodies following domestic violence.

The psychological effects of experiencing physical violence may result in a level of body dysmorphia (Weaver, et al., 2007). This psychological revulsion to a part or parts of a woman's body is a direct consequence of the physical abuse and associated scarring. This negative self perception of their body negatively impacts on a woman's choice to breast feed, (see section 6.5.3). However, the longevity of the psychological effects of these injuries is evident from the women's narratives. The women talk of their perceptions of their body following injuries sustained from the physical violence. They reveal an appearance related dislike of parts of their body following scarring and injuries resulting from physical assaults.

> I wouldn't show my legs and I wouldn't show a bit of my body... I'm all horrible with all the scars on me basically from the violent relationship. There's just so many I wish they would just go really. It's the contact and touching. At the time I had him [baby] I couldn't let anyone touch me I would just rather keep me to myself in my own (Rebecca, pg 12, para 6).

> I hate myself. I hate my body. You see I have to wear things like this [baggy trousers and top] all the time. I have scars on me and my legs have

> permanent bruises. I always wear shell suits or long pants and baggy tops. I can't wear tops and shorts. You see some people out who hardly wear anything, but I can't even wear shorts. I hate my body. I am even worried about if I find someone else how will the bed thing be because he has made me feel dirty (Stacey, pg 5, para 3).

> He did this scar on my face where he hit me with a pool cue erm, he has hit me with a few weapons but he actually did that with a bag with a bottle [points to 2 inch scar on forehead] and he swung it and he stopped me from going to the hospital which is why it has scarred so badly. I am conscious of it and have a complex about it now with it being on my face I can see it when I look in the mirror (Vicky, pg 3, para 1)

Rebecca and Stacey experienced a generalised negative effect on their body image following domestic violence, a repulsion of their own bodies. To explain this phenomenon Weaver argues that a woman's appearance may be altered due to scarring and injury following domestic violence, and this may result in a full or zonal sensitivity to specific areas of their body (Weaver, Resnick, Kokoska, & Etzel, 2007). Vicky's excerpt reveals a more specific or zonal body dysmorphia as she refers to the scar on her forehead. Physical violence has been acknowledged as a component of domestic violence (Krug, 2002), and the injures following this violence has been the focus of contemporary literature (Beck, Freitag & Singer, 1996; Bacchus et al., 2004; Stanko et al., 1997). The extent of the physical injuries experienced by the women are discussed further in chapter 5, section 5.4.3. However in this section, the excerpts from the women's narratives illuminate the psychological impact, and the longevity of the effects of physical violence.

6.6 Asking for help

Women experiencing domestic violence may seek help whilst living with the perpetrator. In this section of the chapter the women talk of their experiences of actively seeking assistance from health care professionals to address the effects of living with the perpetrator. These excerpts reveal the responses to these requests:

> I did actually go to my GP over my little boy because he has got behavioural problems… he has got very angry behaviour problems. I went to the doctor and he turned round and said 'we don't deal with them'. He give me a list of the family centre numbers is because he said he hasn't got a mental health problem. And I said 'I never said he was mental, I wanted someone to help me with his behaviour like' stuff like that, you know, before he gets into a teenager because how am I meant to cope with him then? … But he didn't want to know that either. They don't want to know. If they can't write you a prescription they don't want to know basically… They just pass you off. You know I was shocked when he said 'we don't deal with problems like him, he's not mentally ill' (Orange, pg 5, para 3).

> My doctor wasn't doing nothing for me though, you know test for the courts and stuff, he wouldn't do nothing like that. Well that's my big reason for me not getting my baby back because I was meant to have alcohol tests every month and my doctor was meant to sort that out for me and he never. He has not done nothing for me you know what I mean ...He [doctor] is my problem, he won't listen to me. I have tried to talk to him…the doctor, he gave me depression tablets when he knew I was, I had overdosed on them.

> He was still giving me the same tablets. It is like he doesn't care. How does that make me feel? It is like you always think you can turn to your doctor to talk to, and for help, medical help… and I need to ask for medical advice and I won't go to my doctor. It is like I am scared to go and see my doctor (Daisy, pg 6, para 2).

Feminist methodology includes theories of power and questions who has the power to know what, and they further propose the questioning of the relationship between the medical profession and the women they treat (Ramazanoğlu & Holland, 2002). In these excerpts the women reveal the power of knowledge, their inner knowledge about their specific needs. Indeed, Orange has identified a need on behalf of herself and her son. However, the health professionals transfer this power to themselves by then taking ownership of this knowledge, portraying superiority through negation of her request. Moreover, Postmus, Severson, Berry and Yoo (2009) argue that although women may turn to services including the health service for help, it is these institutional barriers that may result in further difficulties for the women, as shown by the fact that Daisy talks of her fears of approaching her doctor. Heath (2008) suggests that when women access health care following domestic violence, their autonomy and subjectivity should be fully recognised. Yet these excerpts from Orange and Daisy's narratives reveal a disregard for the woman's 'knowledge' and contempt for her request for help by the male doctors, both women identifying the gender of the doctor. Harne and Radford (2008) argue that a woman seeking help from general practitioners may be diverted towards mental health services or given antidepressant medication, rather than an acknowledgment that living with a violent man requires support to leave that relationship. It appears that the authoritative nature of knowledge lies within the domain of the medical profession.

6.7 Discussion

Women often seek medical care for a complaint other than an injury resulting from domestic violence, even though it may be this violence that underpins her complaint. The onus lies upon health care providers to facilitate discussion with all women. Indeed, few women experiencing domestic violence are identified in the health care arena (Edin & Högberg, 2002). None of the women in this study talked of being offered information about domestic violence by any health care professionals despite them all accessing health care provision.

Moreover, the silences revealed in the women's stories and the acquiescent approach of the health care professionals effectively create a conspiracy of silence towards domestic violence from the health care sector. Many women experiencing domestic violence choose to remain silent when accessing health care services. This silence is perhaps a strategy of survival, in an attempt to prevent further violence against them (Siddiqui & Patel, 2003). However, the women's choice to remain silent is reinforced by the reaction of the health care professionals. These silences from within the statutory service serve to condone the perpetrators' actions through non-verbal and verbal messages to abused women, in what I suggest to be an 'I won't ask if you don't tell' culture. Current debate about how to increase the opportunities for women to disclose experiences of domestic violence revolves around the routine questioning approaches within the health service. However, this approach is surrounded by controversy, and it is clear that further research is required to understand the most beneficial and safe system for providing support to women with past or current experiences of domestic violence when accessing the health care system. The recent document 'Responding to violence against women and children – the role of the NHS. The report of the Taskforce on the Health Aspects of Violence Against Women and Children' by the Department of Health (DH, 2010b) now provides health care professionals with a strategic plan. Despite this, it is evident that these

existing recommendations are not carried out, revealed in the responses by health professionals to Sarah (see section 6.4) and Orange (see section 6.2).

This chapter has sought to expand the knowledge on the interaction between women who are experiencing domestic violence and the health service which is supposedly providing help. The women share their stories of being situated in relation to the form of power held by health care providers that have shaped their lives (Ramazanoğlu & Holland, 2002) at different points along the pregnancy/childbirth continuum. The women talk of their perceptions of their body following injuries sustained from the physical violence. They talk of a body dysmorphia (Weaver, et al., 2007) a dislike of the part of their body that has been permanently scarred. These scars and injuries also negatively affect the woman's feelings towards infant feeding. Extending the perception offered in chapter four, the voices of the women have now revealed the rationale underpinning their choice of infant feeding.

The health service has historically been a patriarchal institution in which the response to domestic violence ensures it remains a private issue (Stark, et al., 1979), and Walby and Myhill (2004) suggest that women are more likely than men to experience negative responses to health complaints. By embracing a feminist standpoint the women's voices are heard, revealing how women construct their experiences of their interaction with this institution and perhaps a contemporary patriarchal approach to health care hidden behind a perceived screen of neutrality.

Chapter Seven: Women's Stories of Social Workers' Interventions in their Violent Relationships

7.1 Introduction

Chapter five explored how the perpetrator of domestic violence manipulates the woman into a state of compliant subjugation, ensuring that the violence remains hidden. The preceding chapter explored how women negotiated access to the health care system in response to their experiences of domestic violence. This chapter again focuses on the second aim of the study, and continues this theme of a social response to domestic violence by exploring the women's stories of their interaction with social workers. This chapter also continues in giving subjugated and oppressed women a 'voice' and seeking knowledge from their stories of their interactions with social workers whilst living with an abusive partner.

Continuing this theme of a social response to domestic violence, I have returned to Raven's (1992) elaboration on the theory of social power (French & Raven, 1959) as an explanatory framework and the inter-relationship between the five discrete bases of power, as referred to in chapter five. The interaction between social workers and women living with a perpetrator of domestic violence is explored through the women's stories, leading us to understand the impact of the social worker intervention and the effects on the liberty, autonomy and self-confidence of the women. Furthermore, women experiencing domestic violence hold less power than social workers, and therefore it is from this view point of an oppressed member of society that I seek to understand these interactions. This chapter revolves around the women's talk of their experiences of interacting with social workers which provides a unique standpoint, from which can be viewed their experiences and upon which feminist standpoint theory begins (van Wormer, 2009). Although all the women in this study had children, not all

talked of their experiences of social worker interactions; therefore only those women whose narratives included this experience are presented in this chapter.

The social work profession represents one at the 'cutting edge' for the provision of support for women experiencing domestic violence, being involved in all situations involving the safeguarding of children. Indeed, the nature of this social work role involves the complex inter-relationship between women's personal and societal issues. The Department of Health's 'The changing roles and tasks of social work from service users' perspectives: a literature informed discussion paper' clearly identifies the personal attributes required for social workers to make a meaningful contribution to their profession and clients:

> They place a particular value on social work's social approach, the social work relationship and the positive personal qualities they associate with social workers. The latter include warmth, respect, being non-judgemental, listening, treating people with equality, being trustworthy, openness and honesty, reliability and communicating well (Beresford, 2007, pg 4-5).

The findings within this chapter begin with representations of equity between the women and the social worker, the women talking of the effective support offered by a social worker for the woman's predicament (section 7.2). However, contrary to this experience the subsequent section (7.3) explores the feelings of being threatened by the social worker, akin to the threats extended by the intimate partner. Section 7.4 then explores the women's fears of consequential action by the social worker if she discloses her violent relationship, and reveals how the threat of action by a social worker impacts on the women's self-confidence and trust in the social work agency. Section 7.5 continues this theme, exploring blame apportioning directed onto the women following domestic violence. As the women talk of their

experiences, the power and control wielded by social workers against the women, extending their subjugation, are revealed. The chapter concludes with a discussion in section 7.6.

7.2 A positive experience of social worker interaction

The role of the social worker is a complex one incorporating the provision of support to families and safeguarding marginalised members of society. According to the recent Department of Health (2010a) document 'Building a safe and confident future: implementing the recommendations of the Social Work Task Force', social workers should work with women and their families, seeking to provide individualised care dependent upon their needs. The following two excerpts from Vyvyan and Tulip's narratives talk of the positive nature of their interactions with the social workers:

> I think they can be quite supportive when the woman is quite clear that she wants to leave the relationship, she doesn't want any contact with him and she is working with social services for the same goal. I find them quite supportive then (Vyvyan, pg 4, para 3).

> Well social services got involved because my eldest went into school with bruising on his eye and bruising on his arms so they got involved and then when we were going for meetings and stuff he [ex-partner] started kicking off at meetings and showed his true colours to them so they strongly believed, because there wasn't enough evidence to take it to court, but they strongly believed that he did do it and they advised me to leave the relationship (Tulip, pg 1, para 1).

Tulip's excerpt reveals a representation of equity between woman and social worker. Both women talk of the effective support offered by a social worker to the woman's predicament at this juncture, taking into account service user values, acknowledging what the women say they need and listening to the women's voices. Vyvyan clearly states that social workers can be helpful if the woman is decisive about leaving the violent relationship thereby representing what the social worker wants her to do. Based on a relationship of truth and equality, the efficacy of fulfilling the social worker's role may result in adequate support for the subjugated woman with the effect of her leaving an abusive relationship. Authors have argued for the consistency of feminism within social work (Greene, 2008; Saulnier, 1996; Valentich & Gripton, 1985). Greene (2008) suggests that social workers who draw on a feminist perspective seek to understand the woman's experience from her own standpoint, rather than interpreting her talk within a clinical constraint. There appears to be two subtle sub-themes presented within these two narratives: Tulip refers to the genuine support offered by a social worker in believing her talk and supporting her, whilst Vyvyan talks of the support from social workers if the woman is decisive about leaving the relationship – implying that as long as the woman abides by the social workers' ethos, the provision of support is available. However, later in her narrative Vyvyan talks of a more destructive approach to social worker interactions when the woman diverts from the social workers' demands.

7.3 Fear of informing social workers

Women who live within a relationship in which domestic violence occurs feel threatened by their partners. It also appears that an additional source of threat or fear may be located in the women's interactions with social workers. It is the very genre of oppressive practice that seeks to undermine an individual's self-esteem and confidence. Any oppressive practice may

generate fear, and the women talk of their fears surrounding the consequential actions of social workers if they reveal their violent relationships; these fears have a resultant impact on the woman's self-confidence and trust in the social work agency. The women reveal their fears surrounding social workers, and talk of the reluctance to interact with this statutory agency as a direct effect of these fears:

> They [women] are protective and they have just had the baby and they might feel if they disclose when this is actually going on, then it is the stigma of social services and social services might come and take my baby away so it is best to shut up and do nothing about it (Lily, pg 14, para 1).

> I mean if social services and all that lot are going to report if a woman in domestic violence does come out with stuff like that then they are going to be more scared to come out with stuff. So I think that is what it is with every other woman, they are scared of what the consequences would be if they found out (Sarah, pg 4, para 3).

> I am dead worried about him because if he looks like him [partner] what will I do to him? What if he turns out like him [partner]. I am so worried. I have a social worker but don't know how much I can tell... you know being a social worker it is her job and that, she might take him into care or something (Stacey, pg 5, para 3).

> It is definitely a form of abuse. It is almost a kind of a threat. I have heard horror stories about social workers coming out and saying 'if I find for one minute you're had any contact with him whatsoever we are going to get an

> emergency protection order and the kids are out of here and you won't be getting them back'. It seems to be, they seem to pick their targets as well. It seems to be the young vulnerable women, the women who are not as assertive as the older women or who know their rights as much you know and they are absolutely terrified and like ' oh my God I'm going to get my kids took off me'... and it's just another form of abuse you know. And women are *terrified* of social services because they know they have got that power and they can use that power and they can use threats. I have known them to use threats and they do, yes (Vyvyan, pg 5, para 2).

Women's individual experiences offer a unique perspective into how society functions, and these perspectives seek to give subjugated women a voice, using their stories to reveal the feelings of being threatened. It is due to the nexus of the experience lying within the domain of each woman that provides us with knowledge considered credible (Collins, 1993). The women experience fear, threats and intimidation, with Vyvyan, Sarah and Lily talking about the significant fear of losing custody of their children. Indeed, a parallel appears to exist between threats from the abusive partner and the threat of social services becoming involved: narratives describe both as a threat to the women's children. Stacey talks of a perceived risk of revealing her feelings towards her unborn baby to the social worker, leaving her to deal with her emotions on her own. This paradoxical relationship seeks to undermine the woman's autonomy, isolating her further from accessing any form of help.

Vyvyan describes tactics employed to coerce women into engaging with social workers, tactics which, when employed by a partner, are considered within the range of behaviours constituting domestic violence (Dobash & Dobash, 1992). Each woman's excerpts represent

her own construction of the feeling of fear of social worker interaction, these powerful narratives revealing the hidden power basis which social workers are perceived as having. Indeed, Vyvyan uses the word 'terrified' to indicate the depth of the fear. Daly & Chesney-Lind (1998) draw on critical social theory to place the nexus of violence against women as an issue of power and control. Moreover, these acts are usually equated with the behaviour of a perpetrator; however, as revealed in these women's narratives, the power may also be directed from social workers. Raven (1992) theorised that coercion cannot work without surveillance, or a belief by the victim that she is under surveillance, and this surveillance from a social worker is implied in Vyvyan's words 'if I find for one minute you're had any contact with him whatsoever' (pg 5, para 2, line 2). The Duluth model (Pence & Paymar, 1993) identifies those behaviours that enforce control and surveillance of women. The women in this study revealed professional behaviours aligned to that of male perpetrators of domestic violence. Moreover, whilst the majority of social workers are female (General Social Care Council, 2010), they appear to have become co-opted into the state machinery due to the masculinisation of the social work profession (Keeling & van Wormer, 2011). Power and control issues are thus particularly pertinent for domestic violence survivors given their history of personal victimization and, in many cases, further violation by the social services system.

The interrelationship between the five discrete bases of power (French & Raven, 1959), incorporating coercive, legitimate, referent, expert and informational power, appears to be exposed within these narratives. The women also refer to social workers' oppressive practices that indicate a lack of engagement with the women. Although women turn to services for help, it is these institutional barriers that result in further difficulties for the women (Postmus, et al., 2009).

7.4 Actual consequential actions

These actual consequential actions following the social workers' dialogue with women experiencing domestic violence reveals the true nature of this relationship. The women talk of their involuntary or intentional relationships with the social workers, revealing the lack of ongoing support, empowerment or acknowledgement of the woman's situation:#

> I was scared about child protection and taking my daughter away... I ended up in hospital on a life-support machine for a few weeks and I lost my daughter then, she was took off me. The social worker took her and that's what I am fighting for now (long silence) (Daisy pg, 3, para 2; pg 2, para 1).

> They [social workers] don't help me with my daughter though. 'Gill', she works here, she is the one who has supported me more through my daughter than the social worker. She does the social worker's job for me really. She shouldn't be but she is (Daisy, pg 8, para 1).

> He followed me everywhere for about a year. I went to people for help, went to social services but they weren't any good (Vicky, pg 4, para 7).

> I told my social worker because I got social services and everything involved, all these people on the case and erm they said they were going to close my case because I'm not a risk to the child, it is him (Stacey, pg 2, para 1).

The response from social workers to women who seek their help, such as Stacey and Vicky, may portray unintended messages to the women. A supportive approach signals belief in the

woman's needs and legitimises her claims. However, as revealed in these narratives, an opposing response minimises the experience, deterring them from seeking subsequent help and thereby resulting in increased vulnerability (Harne & Radford, 2008). Daisy has had her child removed by social workers. She identifies the support she feels she should receive from them, talking about the role of her care worker 'Gill' in providing this level of care. Women welcome a 'hands-on' approach, which takes account of both personal and social issues and the associated complex inter-relations (Beresford, 2007).

7.5 Being blamed for domestic violence

Having explored the fear of social worker interactions and the actual consequences of this interaction, I now explore the interactions between the women experiencing domestic violence and social workers at a deeper and more personal level: apportioning blame for these experiences. It appears that the personal attitude of the social worker is indicative of the reaction to, and support of, the women experiencing domestic violence. Both of these personal aspects are reflected within the dynamics of social power which is situated within the domain of the social worker (French & Raven, 1959). The women's stories reveal the interplay of psychological intimidation and coercive threats, underpinned by a legitimate power base:

> Everything is monitored. I mean *everything* you know. It would be difficult enough if you're not in an abusive relationship if someone is monitoring how you are looking after your children and what your lifestyle is and to go through that abuse and then having the pressure of having to justify yourself you know several times a week it is absolutely awful for them. It is. It is an unrealistic level of time that they are not returned because it is a catch-22 situation and the longer it goes on the less chance of getting your children

> back and a lot of it is down to the court system and social services are very slow at doing their reports, and a lot of the time it has to be adjourned you know because the social worker hasn't done the report you know and we are talking about people's lives here and also they are not supportive in getting custody (Vyvyan, pg 5, para 3).

> They got in touch with social services. Social services come out and said I have put my kids at risk. And that was it. I didn't need that... I just turned round and said I never said nothing I never said I was in a domestic violence relationship so I wasn't going to have that, people are meant to be there to help you and they are not meant to do that (Sarah, pg 4, para 2).

> I didn't know the school had actually referred us on so social services had got involved and you know they said he has to leave or we have to come and take the children because you're not safeguarding them (Lily, pg 2, para 2).

The women talk of their experiences following the use of the tactics deployed by the social workers which could be seen as cultural signifiers of providers of assistance in the safeguarding of children. However, paradoxically, this process is an exercise of power by the social workers, either intentional or not, but beginning a process designed to subjugate the woman and limit her autonomy and confidence. Through this process the women are given ultimatums which are perceived by them as threats. In terms of Raven's (1992) elaboration on the theory of social power (French & Raven, 1959), the exercise of coercive, legitimate and referential power by the social workers is evident. They have the perceived and actual

ability to punish the women if they do not comply with the social workers' demands. Minow (1990: 392) argues that this social failure to intervene 'should not be seen as separate from the violence, but as part of the violence'. For example, Lily talks of the social workers' demand that 'he has to go or the children go' (pg 14, para 1, line 3), a direct threat legitimised by the statutory role of social work. The institutional power structure governing social work practice, visible through the statutory role, challenges the relationship with the women (Bundy-Fazioli et al., 2009), and one that feminist social workers have been critical of (Dominelli, 2002). The power afforded to social workers may be negatively influenced by their professional judgement and perceptions of women experiencing domestic violence (Mahoney 1996). Vyvyan's comment 'everything is monitored. I mean *everything* you know' (pg 4, para 3, line 1) aligns with the ethos of Jeremy Bentham's panopticon prison. Moreover, Raven (1992) theorised that coercion cannot work without surveillance or a belief by the victim that she is under surveillance. Although there are obvious limitations in monitoring women, Vyvyan's talk suggests that it *feels* like a continual process. Indeed, the social worker's aim is to ensure the woman severs contact with the perpetrator; but by using what is perceived by the women as psychological intimidatory techniques which mimic those used by the perpetrator, the women self-regulate their behaviour and stop seeing the perpetrator as an act of compliance to the legitimate and referential power and coercive control implicit within the social worker's response, rather than making their own decision. Furthermore, helping professionals including social workers sometimes blame the victims of domestic violence for their predicament, reinforcing other messages that our society sends to these women (Sandel, 2003). These negative messages serve to further subjugate women who experience domestic violence. The emphasis on the blame being apportioned to the woman rather than the male perpetrator strengthens the notion that contemporary society remains patriarchal (Rubin, 2008). Haaken (2010) argues that a woman's capacity to protect her children, or recognise the

seriousness of the situation may be adversely affected following her own experience of domestic violence. Walker (1990) articulated this point clearly following a high profile case in the 1980's, a case considered pivotal in shaping feminist theory in relation to domestic violence (Hanmer, 2002).

From these women's excerpts, the apparent paradox between the social workers' negativity towards mothers experiencing domestic violence, and the woman's greater need of support at the time is evident. Humphreys (2007) argues that women are commonly held responsible for domestic violence, with an expectation of protecting their children from it, and to leave their partners; a failure to achieve this often results in blame apportioning.

7.6 Discussion

Feminist standpoint researchers locate a woman's lived experience at the centre of the research and use it to understand the functionality of society. It also focuses on who knows what and how knowledge is legitimised. This chapter centres on a woman's experience of the interaction with social workers following domestic violence, with the nexus of the experience lying within the domain of the woman. Brooks & Hesse-Biber (2007) posit that this then reclaims their subjugated knowledge and also illuminates oppressive societal practices. Pence and Paymar (1993) recognise that the issue of a man's control over a woman is a theme that runs throughout our society (Sandel, 2003), yet here, listening to the women's voices, this dominance is also expressed by social workers. Mullender (1996) argues that social workers have traditionally been a contributor to the problem of women's experiences of domestic violence. This is certainly true based on these women's narratives. However, contrary to trying to exploit the weaknesses within the social work role, I have attempted to identify how the personal considerations of social workers negate women's desire to tell them

of their experiences; and further, that their use of tactics parallels those of perpetrators seeking to undermine a woman's autonomy and increase her subjugation. It is these characteristics that need addressing within contemporary society.

However social workers themselves are under pressure and high profile cases such as Victoria Climbié (House of Commons, 2003) and Baby P (Local Safeguarding Children Board Haringey, 2009) serve to further compel the social work profession to be more efficient in terms of the 'market driven economy' (Dominelli, 2002: 51). The bifocal pressure exerted from the Government and society enforce the role of helping and controlling people, yet, social workers continue to be publicly criticised for failing women and children.
This scenario has been positioned at a societal level, identifying the social work practice transcending statute to cater for globalisation and market forces (Dominelli, 2009).

Women who have experienced domestic violence are generally keen to engage in the development of service provision and policy development (Hague, 2000), and therefore both the UK and USA have witnessed the growth of a number of domestic violence survivor forums in which survivors are instrumental in setting up or providing services themselves in a professional capacity. Within these established forums the success of domestic violence survivors working together has been clearly identified with successful incorporation of their recommendations to improve preventative work (Hague, 2005). These recommendations include listening to survivors' views, professionals sharing their power, and ensuring that all voices are heard in the policy making process (Hague, 2005). It is suggested that embracing this approach may lead to the provision of a favourable climate of trust and empowerment, thereby effectively engaging women with social workers so they can strive *together* to ensure the safety of the woman and her family through the provision of family centred care.

Beresford (2007) argues that service users value the support that social workers can provide, as well as their ability to help them access and negotiate support from other services and agencies.

Chapter Eight: Women's Experiences of Police Intervention in Domestic Violence

8.1 Introduction

Chapters five, six and seven have identified how the perpetrator manipulates the woman into a state of compliant subjugation and ensures that the violence remains hidden from statutory agencies despite the woman's interaction with statutory agencies. This chapter focuses on the second aim of the study as it continues the theme of social responses to domestic violence, exploring the women's stories of their relations with first response police officers following domestic violence incidents. The women tell their stories about experiences of police intervention following domestic violence or harassment by their partners. Following the contact with the law enforcement agency, the women may feel disempowered once their case is being pursued by the legal system (Belknap, 2007). The relegation of the women to a passive role within the prosecution system challenges the standpoint feminist emphasis on self-determination (Bui, 2007).

The police are often the front line professionals who are first to respond and become involved in incidents of domestic violence, and their approach underpins the women's perceptions of police support (section 8.2.1) and, further, acts as the entry point for legal recourse (Benson, 2010). Furthermore, at this juncture of the relationship, the abundance of opportunities available to police to collect evidence is unique, and this evidence can play a pivotal role in the actions of the Crown Prosecution Service. These opportunities for the recording of evidence, which underpin the prosecution of perpetrators through the Criminal Justice System, are revealed in the women's narratives in section 8.2.2.

Collectively, the criminal justice system recognises the problematic issue of retraction of statements following an incident of domestic violence. Robinson and Cook (2006) identify policy initiatives that have been an integral part of enhancing the support offered to women disclosing domestic violence, with the intention of augmenting the number of women deciding to continue with their cases instead of retracting their statements. Although policy initiatives may increase successful recourse to prosecution, these women's stories suggest a more personal aspect of policing might inform this approach (section 8.2.3). The issue of preserving domestic violence as a 'private issue' are explored in section 8.3. Responses from the first response officer and how these negate a woman's desire to disclose domestic violence are also explored.

8.2 Findings

The findings are presented as three interlinked themes. The first explores the initial responses of the police to an incident of domestic violence. The women's stories reveal experiences of police intervention following physical assault or harassment by the partner. Excerpts from their narratives reveal vivid and detailed descriptions of the incident, the women's emotional responses and the behaviours of the first response officers to a woman in crisis. The second theme relates to the collection of evidence following an incident of domestic violence, evidence which underpins the trajectory of domestic violence cases through the legal system. The findings explore through the women's voices their experiences of retraction of statements or withdrawal of support by the police following an assault. Finally, there is an exploration of how the police support a conspiracy of silencing these women, reducing their opportunities to disclose domestic violence through a process of disempowerment, lack of recognition of their experiences and denial.

8.2.1 Initial police response

The initial police response to a woman calling for help following an experience of domestic violence is significant in that they may be responding to a woman's first call or during an incident in which she is fearful for her life. It is unlikely that this will be her first experience of domestic violence as women may have experienced up to thirty five incidences of domestic violence before they call for police support (Jaffe, 2006). The sensitivity with which the police respond to this incident may portray negative or positive messages to the woman. A sensitive and supportive approach signals belief in the woman's words and legitimises her claims, whilst the contrasting response minimises the experience, deterring her from seeking subsequent help and resulting in increased vulnerability (Harne & Radford, 2008). The following excerpts from the women's narratives reveal their interactions with the first response officers following domestic violence:

> No I was very desperate, and the children had actually rung them as well, they rung from another room saying like daddy is hurting mum. So they [police] have come out and intervened and he [ex-partner] stood there saying, 'Oh no there is nothing going on, we have just had a bit of a talk, a heated discussion but that is it.' And the police opened the front door... and the police always were taken into the kitchen right ahead and I was always in the living room and they always used to go to talk to him first and then come to me right when they were leaving and not even ask me anything and not ask me what had gone wrong, what it was about, see, they saw I had handprints on my face and my eyes were red and I was crying and my eyes so swollen, you know, I can't breathe because I'm crying that hard, and they used to say, 'I'm going now, everything is all right' (Lily, pg 11, para 2),

> I think it is very much down to the police officer who goes out. I think a lot of it is down to attitudes as well because I'm sure they are all trained on domestic violence, but actually putting that into practice and policing is a different thing, you know. I think especially where alcohol is involved as well because a lot of women use alcohol as a coping mechanism and when you delve into their lives you can see why, but the police, as soon as they smell alcohol, it's six of one half, half a dozen of the other, isn't it, their attitude, you know (Vyvyan, pg 3, para 3).

> I'd call them up as he had done something to me and the police arrived and she was really horrible she was just, she was an older one, I think she didn't understand the full extent but these days the younger ones have got more training in that aspect of things and they understand it more, but this particular one she was, she was not very good… So after that I didn't have the confidence to (pause) make a statement (Vicky, pg 4, para 1).

> Some of the police officers, it was like an effort just to make a statement. They would say he is only banging on the window. I said, 'Well what you want him to do, kill me then and then you'll take it seriously?' (Orange, pg 3, para 3)

Feminists stress the importance of narratives voicing the experiences of previously silenced groups of women (Harding, 1987; Reinharz, 1992; Riessman, 2008). These women's voices have been silenced through living with a coercive and abusive partner, but also through

having experienced societal ‘silencing’. The negative police responses serve to undermine the women’s autonomy and may also be interpreted as condoning the behaviour of the abusive partner. The resultant effect is for the women to remain silent, as clearly articulated by Vicky: ‘After that I didn't have the confidence to make a statement’ (pg 4, para 1, line 2). These narratives of the interaction between the first response police officers and the women following an incident of domestic violence reveal a tolerance to the perpetrators’ behaviour. The women’s stories reveal silences in the form of non-disclosure following physical violence, and these silences are perpetuated through the lack of support offered from law enforcement personnel. The lack of support by attending police officers is clear. These crimes remain unreported, silenced through an inappropriate response. In the USA a study involving 12 major cities identified that 9.8% of women had experienced abuse within the previous two years (Walton-Moss, et al., 2005). The British Crime Survey (BCS) reported that in the UK domestic violence accounted for 16% of all reported violent incidents during 2007–08 with the majority of victims being women (Povey, Coleman, Kaiza, & Roe, 2009). Given the experiences of the women in this study, these figures suggest a disparity between recorded and attended incidents, thereby making it challenging to estimate the actual incidence.

Point 5.1 of the CPS policy (Crown Prosecution Service, 2009b: 18) states ‘We will work closely with the police to make sure that all available evidence from all sources has been gathered and brought to our attention as quickly as possible’. Yet these women’s stories reveal disregard for this process and, further, a disregard for the women’s future safety. Lily’s narrative clearly identifies her terror of her partner and she signifies this to the attending officer. Orange asks a revealing question – ‘What you want him to do, kill me then?’(pg 3, para 3, line 5) – suggesting her disbelief at the police officers’ response to her call for help. By having their experiences discounted, these women’s fears are compounded and, further,

their personal safety is compromised. The National Policing Improvement Agency (NPIA) have produced, on behalf of the Association of Chief Police Officers (2004), clear guidance on the 'Duty of Positive Action' underpinned by the Human Rights Act (Her Majesty's Court Service, 1998), ensuring adequate protection for victims of domestic violence. The Government and its legislation may be defined by aiming to 'shape, guide or affect the conduct of some person or persons' (Gordon 1991: 2) and this conduct serves to regulate statutory workers such as the police. Foucault (1982) argues that the governmental power exerted through these statutory agencies, and then becomes part of a network that polices the state. As the responsibility for identification of, and support for, women experiencing domestic violence expands, so has the requirements for these statutory agencies to develop policies to define accessibility rights to their mechanisms of support (Bumiller, 2008). Through this regulation, women's experiences may become hidden within this dimension in what Garland (2001) argues is a culture of control.

Having shared these experiences of police intervention, the women's stories went on to describe further episodes of domestic violence, signalling that the police intervention did indeed leave them exposed to further attacks from their partners. None of the women in this study had contact with the Police Domestic Violence Units suggesting that the statutory recommendations were either not followed.

In what Livesey refers to as 'tellability', it is acknowledged that it is the listener who can 'retain control over the construction of meaning within the disclosure event' (Livesey, 2002b: 63). As is evident from Vicky and Lily's narratives, the police used this power to construct a different meaning for the event than the women themselves, thereby negating their experiences.

8.2.2 See no evil, hear no evil

This section continues to build on the phenomenon first identified in chapter five: the silence of many women when faced with disclosing domestic violence. The literature review explored previous studies that go some way to explain this phenomenon, yet in these women's stories we reveal a more profound institutional effect that negates a woman's desire to share her experiences of violence within the home.

The attendance of the police at an incident of domestic violence provides a unique opportunity to gather evidence for the purposes of prosecution. The resultant evidence may then be used by the Crown Prosecution Service, affecting the outcome of any criminal proceedings (CPS, 2009a). This enhanced evidence gathering underpins the subsequent legal response and plays a pivotal role in criminal prosecutions. The following excerpts from the women's stories reveal the availability of evidence presented to police and the responses proffered by the attending officers:

> He ran when I said I had called the police, he ran and I said to them [police] the knife is in the drawer, but because the knife amnesty thing had passed they said well we would rather you not tell us about that. But I said well why because that is the knife he has threatened me with, I am not going to go into the drawer I said because he will be watching from outside. That was how fearful I was, I just didn't know where he was looking and erm I said, 'The drawer, it's there in the drawer.' So they went up, opened the drawer, saw the knife and said, he said, 'It's best you not telling us about that now like', he said, 'because it is in your house and you are in here and you will get the consequences over that.' So I said that, 'My fingerprints

> aren't on it. I have never touched it', I said, 'his prints are on it, he has touched the knife, he put it in there not me.' And he said, 'No, we will say nothing more.' (Lily, pg 10, para 2)

> He [husband] coming round banging on the doors, on the windows and following me. He wouldn't leave me alone. I would find him asleep in my garden one morning. So I had to keep doing it [calling police] for the baby's sake... They never even came out half the time. A lot of the time they never come out... I would call them when he [husband] was banging on the windows and he came out and the police officer turned round and said, 'It wouldn't do any harm just for him [husband] to see him [son].' I said but the point is I have got an injunction against him, a restraining order. He is not meant to come here or anywhere near me or my little boy but the copper turned round and said 'Well it wouldn't do him any harm'! (Orange, pg 3, para 2)

The primary focus of feminist research is to afford previously silenced women a voice to reclaim their subjugated knowledge and illuminate oppressive societal practices (Brooks, 2007). These narratives provide a medium through which the women's voices can be heard. The oppression exerted by the attending police officer negates the seriousness of the situation, as clearly demonstrated by Lily and Orange's experiences. The failure to collect evidence following Lily's interaction with the police negated her experiences and thwarted any recognition of her experience within the legal processes. This lack of evidence then affects the trajectory of domestic violence cases through the legal system. The suppression of the women's concerns legitimises the action of the perpetrator and indicates a wider societal

view of tolerance to domestic violence. It is argued that patriarchal societies continue to provide a safe harbour to men who choose to control, subjugate and harm their female partners (Bennett, 2006). Foucault's model on power and dominance is especially relevant as the women attempt to resume their relationship with their abusive partner, but have also been forced to turn to a modern institution of the police force, that may have left them exposed to revicitimisation (Bumiller, 2008). Power and control issues are thus particularly pertinent for domestic violence survivors given their history of personal victimization and, in many cases, further violation by the social services system.

Feminist standpoint research asserts that women's individual experiences offer a unique perspective into how society functions. Moreover, as discussed earlier, Collins (1993) posits that when identifying knowledge it is women's 'concrete experience' that provides the ultimate criterion for the credibility of this knowledge. Each woman in this study shared her own constructed reality based on individual experience. However, also apparent within these stories is a commonality of experience: the effects of the negotiation between themselves and the first response officers. The stories reveal a conspiracy of silence by the attending officers, a denial of seeing and hearing ('see no evil, hear no evil'), leading to further derailment of the woman's self-esteem and increased self-doubt with regard to the validity of her feelings following domestic violence.

8.2.3 Retraction of statements/support

Women might regret making a statement following an incident involving domestic violence and choose to retract their statement. There are many reasons underlying this decision including fear of retaliation, lack of financial resources or wanting to maintain the relationship in some form (Gill, 2004). Research suggests that this decision is affected by

police practice (Harne & Radford, 2008). The recording of a statement is dependent on the attending officers recognising and acknowledging the incident as a crime. They can use their discretion and base their decisions on individual ideologies or judgments about the aggressor, sometimes leading to the arrest of both the perpetrator and the female victim (Ferraro, 1989). The result of this approach is to further undermine the woman's autonomy and self-confidence leading to re-victimisation (Harne & Radford, 2008):

> Well I have been to the retraction clinic with women who, who have been adamant about retracting, erm, and when they [police] have got there it is made quite clear from the outset that if they have been forced into a retraction or they think they have been forced into a retraction then they are not going to accept that because they are being coerced by the ex-partner or the ex-partner's family… it is put over in a threatening manner… The woman's defences are up and erm she's terrified of saying the wrong thing in case she can't retract it. A lot of the time it is quite threatening because the conversation goes down the line of, 'Well you probably will be subpoenaed anyway so you are wasting your time'… So they [police] are quite forceful with them and try and put them off retraction which I don't think is fair because they have been through enough anyway and to me it is just another form of abuse, it is another form of pressure and control (Vyvyan, pg 2, para 1).

> So I have made statements and retracted it and then I get a £60 fine at the end of it. They done me for wasting police time. They knew about the violence because they were getting called out to my house all the time [sounds agitated when saying this] every week, you know what I mean,

> they knew but they done me for it… I know there was one policeman, his name was PC and he was nice when I was doing the statement and but when I had retracted it he was nasty, you know what I mean. That's when he did me, he gave me a £80 fine (long silence) (Daisy, pg 2, paras 2 & 3).

Both Daisy and Vyvyan's stories reveal the paucity of police support at the earliest stage of the prosecution process, exacerbated by penalising these women for their retracted statements. The lack of police support is clear from both these women's stories; but the deeper and perhaps more profound issues appear to be the victim blaming and the emphasis on the woman being the criminal for retraction or indeed reporting the crime. This behaviour not only serves to further undermine the woman's autonomy, but also condones the behaviour of the abusive partner.

Retraction of statements is only one of several reasons for the high attrition rates of domestic violence cases (Robinson & Cook, 2006). One UK study revealed that although an arrest occurred in three quarters of incidents of domestic violence in which an arrestable offence was committed, less than a third actually led to a criminal conviction (Hester & Westmarland, 2005). The CPS cite the most common reasons for attrition as being the victim wanting no further action or retracting their statement (Her Majesty's Crown Prosecution Service Inspectorate, 2004). High rates of attrition might be diminished through provision of effective and ongoing support to reduce the anxieties arising from interaction with the criminal justice process (Hester & Westmarland, 2005). Counteracting retraction, the CPS (Starmer QC, 2011) now instructs the police to assume that the women may not support the prosecution of her violent partner when they prepare a case for prosecution. Whilst the CPS may intend to prosecute a violent man, Vyvyan reveals the resultant effect on the woman.

8.3 Experiencing police oppression

Male dominated ideology has led to blame for domestic violence being placed on the woman, leading to societal gender based oppression (Buzawa & Buzawa, 2003). Even when the police are called to an incident, the perpetrator may not be arrested or even questioned. The first response officers may instead exercise discretion based on their own ideological beliefs and thereby fail to identify the primary aggressor (DeHart, 2008). The following excerpts from the women's stories provide an insight into their experiences of police oppression and domination:

> So later on he came back home absolutely stinking drunk, you know, and he has kicked off and he has gone berserk and he said, 'So yes I am better than you.' So obviously it is a fear of his. And I can see that now. But the police got called and I got removed. The children were all in bed, my son was 2, daughter was 4, the next one up was 7 and the next one up was 9. I got removed and they allowed him to stay in the house (Lily, pg 8, para 1).

> And then he just started harassing me and started harassing Andy again, then it just started to get really bad but then I went to the police station and he turned up and he then he rang his dad to come and I got a warning. I got a verbal warning to stay away from him! And he chucked a bottle at my windscreen and smashing the screen and he kicked the side of my car and we both got a warning. He kicked it all in the front panel so my dad had to do that, and me and the ex got a verbal warning. He got a verbal warning and I got one. I got a verbal warning for doing nothing, it was horrible. I didn't report anything after that (Rebecca, pg 5, para 4).

> I thought they were against me, you know what I mean, like they were giving him the right to go ahead and do what he was doing, which I don't agree with because people in this situation like I was in, when they go to the police for help and when you get done for something he has done, it makes you feel bad about the police then, you know what I mean, you can't rely on them, you know (Daisy, pg 2, para 3).

> When they did arrest him they let him go, he told them [police] that I had taken drugs and I made it all up so they just let him go, so I was really upset about that. So after that I didn't have the confidence to (pause) make a statement (Vicky, pg 4, para 1).

> And I have known police to interview the woman in the presence of his family, erm, and that has not just happened on one occasion either, you know, and his mum has interjected saying, 'Oh yes, they are as bad as each other, these two.' The last time it happened I even said to the woman, 'Were the police aware that it was his mum, they might have thought it was your mum?' and she said no because she introduced herself as soon as they walked in because they lived in her house (Vyvyan, pg 3, para 4).

The role of the responding police officer and the ensuing interaction with both victim and perpetrator must be carefully balanced whilst consideration is given to pursuing all available lines of enquiry in line with current legislation. The Human Rights Act (Her Majesty's Court Service, 1998) places an obligation on attending police officers to take positive action where there are reasonable preventative operational measures to avoid an immediate risk. A

perceived lack of powers of arrest may negate this action (Richards, et al., 2008), despite the first response officer observing a power imbalance within the relationship and evidence suggesting domestic violence. Lily, Rebecca and Daisy all talk of the blame apportioned by the police following domestic violence. The Domestic Violence, Crime and Victims Act (2004) allows the police increased autonomy to effectively deal with offenders whilst crucially managing victim safety, and the Serious Organised Crime and Police Act (Her Majesty's Court Service, 2005) enables immediate protection to be made available for the victim during a time of crisis whilst arresting the person suspected of committing an offence. However this is not the reality for the women in this study. Therefore, assuming the first response officers are familiar with these statutes, this suggests that more personal issues are underpinning the officer's responses. Harding suggests that gender difference and competing narratives are a resource which allows questions to be asked about social relations from the perspective of those who are 'systematically oppressed, exploited and dominated' (Harding, 1991: 150). These women's stories of their interaction with first response officers suggest, as argued by DeHart (2008), that the police officers' individual beliefs take precedence over their professional remit in responding to women disclosing domestic violence.

8.4 Discussion

The women's excerpts have provided opportunities to uncover how the public-private boundaries of policing shift and dissolve, why statute concerns override the women's individual interests, and how police officers enact their first response so that they are more beneficial to themselves than the women seeking help. This intersection of organisational and interpersonal forces that serve to render women invisible and reinforce victim blaming following domestic violence are apparent. Despite the policy of mandatory arrest and prosecution of perpetrators of domestic violence, there are unintended consequences for the

women (van Wormer & Roberts, 2009). Bumiller, (2008) argues that this intervention may disadvantage marginalised women further by dual arrests or unwanted interventions by the state.

The inappropriate action of *inaction* legitimises the perpetrators' behaviour. Furthermore, it is indicative of a wider societal view of tolerance to domestic violence against women. Appropriate police action following attendance at domestic violence incident signals intolerance to domestic violence, and may empower women experiencing violence and intimidation to recognise their experience as a crime. Feminists have argued that failures to intervene and to arrest the perpetrators of domestic violence further endorses the patriarchal oppression of women (Hanmer, 1989). These negative responses also serve to undermine the women's autonomy, causing the women to remain silent and increasing their vulnerability. In relational terms many abused women do not want their partners arrested, but want the violence and intimidation to stop.

Liberal feminist criminologists posit the 'sameness' of men and women, but state that women are inhibited from the opportunities given to men (McLaughlin & Muncie, 2003). However the women's voices reveal a more sinister nature of policing, a more androcentric approach, in which the police reinforce the perpetrator's behaviour by discounting the woman's experiences and compounding her lack of confidence. Drawing on critical social theories, feminist criminologists focus on the gender differences in terms of power, and relate this to crime and the criminal justice system (McLaughlin & Muncie, 2003).

The collection of evidence underpins both the recognition of domestic violence as a crime and the prospective process of legal proceedings by the Crown Prosecution Service. The

women's stories reveal disregard for this process and, further, a disregard for the women's future safety. They reveal a societal and legislative tolerance to domestic violence. The patriarchal society in which we live continues to provide a safe harbour to men who choose to control, subjugate and harm their female partners.

The understanding of the various causes and full consequences of retraction remains limited (Robinson & Cook, 2006). This chapter attempts to offer some explanation for this action, revealing both personal implications for the woman, and the change in police attitudes after this action has taken place.

Studies have revealed the benefits of a co-ordinated community response to domestic violence (Robinson, 2006). Additionally, protection work provides support for all victims through the criminal and civil justice systems, from the initial response to court proceedings (Home Office, 2009). An effective criminal justice system and a cohesive support network for women will serve to strengthen the woman's resolve and create a conducive personal and societal approach to domestic violence.

The woman's stories have been presented using a feminist standpoint as the theoretical framework (Hesse-Biber & Leavy, 2007). However, whilst I have striven to represent each woman within this thesis, the significant depth and breadth of the women's stories has resulted in only excerpts being presented. Thus, these excerpts represent only a small section of their narratives. Further excerpts have been included in papers submitted for publication with the aim of sharing the women's knowledge and experiences with a wider audience, and attempting to 'give voice' to these previously silenced women.

Chapter Nine: Conclusion

9.1 Introduction

This chapter initially presents a summary of the thesis, providing an overview of the two strands of the study. The first strand explored the prevalence rates of domestic violence reported by a sample of postnatal women. Using a narrative approach to interviewing, the second strand explored the experiences of fifteen other women encountering domestic violence and their attempts to access support from statutory agencies. This chapter then presents a synthesis of both strands and an acknowledgement of the limitations of the study. The chapter concludes with a list of recommendations for each statutory agency, identifies what contribution the thesis offers in terms of new knowledge and identifies the direction for further research based on the findings presented within this thesis.

The foundation on which the study was developed was recognition that the women participating were those who had experienced domestic violence and had been living with a coercive and subjugating partner. I therefore considered it essential to address these factors both within the research proposal and when seeking ethical approval (chapter 3, section 3.5). It is acknowledged that there are several epistemologies, theoretical frameworks and methods that could have been chosen to conduct this study. Understanding the dynamics within relationships in which women experience domestic violence, I have been influenced by a feminist standpoint epistemology (chapter three, section 3.2.1).

9.2 Summary

The thesis set out to explore the prevalence of domestic violence experienced in pregnancy as reported by a sample of women in the immediate postnatal period. It was fortuitous that immediately prior to commencing this study I had conducted several other research studies replicating the methodology but accessing different samples within the same hospital, thereby enabling the comparison of data. Previous isolated studies revealed a prevalence of domestic violence in pregnancy of between 6% and 21 % (Campbell, et al., 2000). The findings from the first quantitative study are consistent with the lower rates reported in the literature. However, unusually, I was able to compare these rates in the postnatal period with those from samples of women who attended other clinics within the same hospital. The statistical analysis of the findings (see chapter 4, section 4.3) revealed that women may refrain from disclosure of domestic violence at specific points on the pregnancy/childbirth continuum, making visible for the first time the inhibitory response to disclosing domestic violence at this time in a woman's life. This has implications for health care providers, which are discussed in chapter 6.

To further explore this phenomenon, a second study using narrative interviews involved fifteen women, offering an understanding of the women's experiences of disclosure in pregnancy and following childbirth. According to Brooks (2007: 56), this 'concrete experience' should be the entry point for research in order to expose new knowledge offered in women's narratives, allowing feminist standpoint researchers to permeate the gaps in this knowledge from this perspective. Threats and coercive behaviours serve as subjugation and negate the women's willingness to disclose domestic violence. Moreover, from exploring the women's narratives it appears that this subjugation extends beyond the boundaries of the

relationship, extending into a wider societal issue with threats and coercion also arising from within the statutory agencies designed to protect the woman (chapters six, seven and eight).

There is a connection in the underlying methodology between the quantitative strand and the narrative strand. Reinharz (1992) argues that using a single method of research to explore women's lives may be inadequate, and that using a mixed method approach affords the feminist researcher an opportunity to more fully identify what other research methods may omit. Chapter three continued this argument by identifying how a feminist multi-layered approach enabled the researcher to gather complex and layered data (Leckenby & Hesse-Biber, 2007).

Following the first quantitative study (chapter four), the experiences of the women were explored in a richer context through the use of narratives (presented in chapter's five to eight). The intention of the narrative study was to hear subjugated women's stories and to gain a deeper understanding of the new knowledge of disclosure of domestic violence, thereby building on the knowledge generated from the first study.

Feminist research is based on the question of who knows what and how their knowledge is legitimised (Harding, 2004). Placing women at the centre of the research process in order to gain an accurate and authentic understanding of their concrete experiences provides a tool for understanding the wider social world incorporating the personal and the political.

Feminist standpoint is largely rooted in Marxist ideologies of social power (Chafetz, 1997), and so the theory of social power (French & Raven, 1959) was utilised as an explanatory framework for coercive control and provided the theoretical basis for the analysis. Chapter

six explored the women's experiences of accessing health care. Schneider (2000) refers to the 'generality' of coercive control, yet in chapters seven and eight the women talk of the explicit use by police officers and social workers of social power through the dynamic use of the five discrete power bases (French & Raven, 1959). Surreptitiously coercing the women to accept the statutory agencies' response causes further subjugation of the women. Women refrain from spontaneous disclosure of domestic violence (O'Campo, et al., 2008), and many reasons for non-disclosure have been reported (Battaglia, et al., 2003); the findings in chapter six add to this knowledge, revealing a predominantly acquiescent approach by health care professionals to women despite visible injuries suggestive of domestic violence. The Home Office (2009) in the UK advocates that those in public services ought to play a more significant role in identifying early signs of violence and providing better support for its victims. Many do identify the signs of domestic violence, but choose to disregard them.

Identifying interactions with women and the statutory agencies that impact on outcomes is therefore necessary for understanding individual experiences and wider societal attitudes to domestic violence. The combination of these two studies has resulted in both of the aims and all four objectives being met, although I acknowledge that the objective of presenting the findings to a wider audience is ongoing.

This study demonstrates that in British contemporary society there is a plethora of policies and statutes to protect women experiencing domestic violence and to support them in accessing effective care from statutory agencies. However, the amalgamation of the responses presented by these statutory agencies serves to undermine women's willingness to ask for help, instead constructing connectivity within a 'conspiracy of silence' (chapters six, seven and eight). Postmus et al, (2009) argue that although women may turn to statutory

services including the health service for help, institutional barriers may result in further difficulties for the women.

9.3 Limitations

The importance of acknowledging the strengths and limitations of any research is recognised as being inherent to the value of the research in terms of applicability, generalisability and comparability (Holloway, 2008). The narrative study is limited as it was a small study of fifteen participants and the sample of women interviewed were white and from a violent heterosexual relationship. Therefore, the findings may be limited. However, I suggest that given the methodological a decisions of the study (see chapter 3), a greater number of participants would not have enhanced the quality of the data collected (see findings chapter five through to eight). By interviewing a more ethnically diverse group of women, this may have introduced additional cultural elements to the study.

A second limitation therefore lies in the lack of ethnic diversity of the women participants in the narrative study. All the women were white and reported a male intimate partner as the perpetrator of the domestic violence from within the context of a heterosexual relationship.

9.4 Talking to the women and the research experience

9.4.1 Autonomy and connection

All the women had experienced subjugation and a lack of autonomy (Stark, 2007), and these considerations were implicit in the development of the methodological decisions for the narrative study. The research issues underpinning the ethical principle of autonomy are detailed elsewhere in the thesis (chapter 3). It is therefore noteworthy to explore the degree of

autonomy within the women's lives and to explore how the methodological decisions within the study have addressed this issue. The degree of autonomy retained by the women within their relationship was revealed in the women's talk of their personal life. This varied for each woman: Rose worked part time and was able to leave the home when she chose; Tulip talked of being '… always stuck in the house all the time, it felt like the walls were closing in on me all the time' (page 2, line 70); and Stacey was kept prisoner in her flat for the two months prior to being released following police intervention, after having her autonomy denied by her abusive partner. At the time of the interview all the women participants were in the process of regaining full autonomy, living without the perpetrator and making their own decisions. To continue this process, I considered the research in an analytical context, including how the perceived power afforded to a researcher may affect the study. Exploring the narratives for evidence of my approach revealed distinct aspects. Firstly, there was evidence in some of the narrative interviews (Sarah, Rebecca, Melanie, Lily and Daisy) of the women commencing talking before I had finished what I was saying. It may be considered that this 'overtalking' represented the woman's perception that she felt empowered to dominate the conversation at that time, regardless as to my role as the investigator.

Secondly, the recruitment method of self selection for participation in the study (see chapter 3) ensured it was the women's *own* choice to participate. In congruence with this approach to recruitment, all but one woman who had made a commitment to meet me did attend for their interview. It appeared that the participating women were committed to the opportunity of being able to tell their story. I am not aware of how many women made preliminary enquiries and decided against participation, as these requests were fielded by the managers of the refuges.

Finally, each woman chose her own pseudonym, demonstrating individuality and autonomy. Most women chose the name of a flower; however Orange chose a colour whilst Vyvyan chose her name, despite it being intentionally male, due to liking a character of the same name within a television comedy programme. The following is an excerpt from Orange's (pg 1, para 1) opening comments:

> **(JK):** So that we can keep our conversation confidential, so no one will know who has said what, please could you choose a pseudonym, a false name to be known by?
>
> **Orange:** I don't know what to choose!
>
> **(JK):** Some women have chosen a name of a flower or plant
>
> **Orange:** I don't like plants or flowers [pause]. [Shrugs shoulders] I can't think of anything.
>
> **(JK):** Would you like me to suggest a few things?
>
> **Orange:** Yes OK.
>
> **(JK):** How about an animal or an object like a vase, or a colour?
>
> **Orange:** Oh I like colours. I like orange and yellow [pause]. I will choose orange.

Here in the last sentence a definitive answer is offered: 'I will choose Orange'. She did not look for any confirmation of acceptance by myself, but made an autonomous decision.

For narrative interviews to generate useful data it is necessary for a connection to exist between the researcher and the participant (Seidman, 2006). I chose to commence each interview with a brief synopsis of my professional background, with no further information being offered nor requested by the women. Reinharz (1983) argues that the researcher should share their own biography to increase rapport with the participant and reduce the hierarchical

position of the researcher. However, Stacey (1991) cautions that whilst recognition of the power afforded to researchers should be acknowledged, becoming too personal with a participant may generate a false sense of equity, leading to the participant revealing more than they intended. Although I attempted to facilitate the connection between us, this connection did not rely on the sharing of *my* personal details. The connection between me as the researcher and the woman participant thus appeared to rely on gender. Finch argues that in woman-woman interviews 'as women interviewees have begun to talk about key areas of their lives in ways which denote a high level of trust… they expect me [Finch] to understand what they mean simply because I am another woman' (Finch, 1984: 76).

Research that involves a sensitive and emotive subject, particularly one accompanied by experiences of violence, may result in a participant becoming upset (Guenette & Marshall, 2009), and some women found recalling their disquieting experiences more challenging than at other times during their interview. Rebecca became tearful when recalling her experiences of sexual violence and Louise was visibly upset when talking of her experience of a social worker removing her newborn baby from her care. Being sensitive to their distress I did not probe further, but acknowledge that data may have been lost. During these incidents the women's speech became more hesitant, becoming interspersed with pauses and longer silences, so transcribing the interviews verbatim has maintained these within the text because as DeVault (2004: 235) argues '…this halting, hesitant, tentative talk signals the realm of not-quite-articulated experience, where standard vocabulary is inadequate, and where a respondent tries to speak from experience and finds language wanting'. The women shared some of their experiences of physical violence in vivid detail, recounting their injuries with such clarity that they also recalled their personal location at the time of the attack (e.g. the kitchen or the bedroom). Using a narrative approach the women chose what part of their

stories to share, yet most of them detailed the violence perpetuated against them, suggesting that a connection had been made between us.

As the interviews came to an end, when each woman identified that they had finished their story, I offered my thanks for participating and ended on a positive theme by acknowledging that I hoped the findings would help other women. Parker and Ulrich (1990) argue that it is important to end an interview on a positive note. Lily's comments in this excerpt, taken from the end of her interview (pg 14, para 2), reveals how she felt about sharing some of her experiences:

> **(JK):** Is there anything else you would like to discuss or comment on?
>
> **Lily:** …I have found it quite interesting because I don't think I've spoken about it for such a long time and I think because I have progressed I have not had a need to speak about it, so on reflection I think that today just talking about this, points to how far I have moved on.

Following the completion of an interview with Sarah, as we headed to the door she disclosed suicidal tendencies. Although this comment was made outside of the boundaries of the interview, it was in my company. I therefore asked Sarah if she felt able to inform the manager of the refuge, which she then proceeded to do in my company. All the women continued to receive counselling as part of their ongoing support from the refuge.

9.4.2 Personal reflections

Although traditionally concern for the wellbeing of research participants has been paramount, there is now a recognition that the researcher is also at risk of harm during the research process (Dickson-Swift, James, Kippen, & Liamputtong, 2008). As recruitment for the study

relied on self referral, three women presented themselves on my first visit to the refuge. After conducting these initial interviews I found myself emotionally challenged: it was emotionally difficult to hear the women talking about their experiences of being beaten, vividly describing the events that led to their injuries and showing me their physical scars. As the women's stories unfolded they talked about one incident after another involving violence, threats, subjugation or negative interactions with statutory agencies. The women spent little time talking about the non-violent episodes in their lives. Despite having provided health care to women for twenty years, and more recently fulfilling the role of a domestic violence co-ordinator, I still felt psychologically unprepared and somewhat upset by the prolific violence and subjugation described in vivid detail in some of the women's stories. Sabin-Farrell and Turpin (2003) identify that hearing other people's experiences of trauma may result in the 'vicarious traumatisation' of the listener in reponse to hearing these stories. Indeed, as I listened to the tape recordings and transcribed the women's stories I was re-immersed within their words, hearing their voices and their expressions as they shared their stories.

As the women spoke, they talked of not recognising the signs of coercion and subjugation until the relationship had become violent. This prompted me, as a woman, with the thought that I too might have missed these signs in my own relationships. I began to critically examine past personal relationships for previously unrecognised signs of domestic violence. This somewhat disconcerting experience also served to challenge my thoughts on my existing long term relationship. Willig (2001: 10) argues that 'personal reflexivity involves thinking about how the research may have affected and possibly changed us, as people and as researchers'. From a personal standpoint this has manifested in a short term change as my questioning and reflection were resolved. However, I acknowledge that for a single woman the resultant impact following the study might have been more significant and have had a

direct impact on future relationships. Jagger supports this notion of emotional acceptance when seeking knowledge and argues that emotions are a 'necessary feature of all knowledge and conceptions of knowledge' (1997: 190). I suggest that had I maintained a reflexive account of my research experience, the processing of these emotions would have been accelerated due to addressing these emotions at an earlier stage during the research process.

Reflexivity is a concept that enables the researcher to understand the differences between themselves and the participant, and is especially relevant within feminist research (Hesse-Biber, 2007). It is also necessary for researchers to identify how these differences will affect the interview situation. Many diverse examples of how these differences have been negotiated to enable positive and effective communication and understanding between the researcher and participants are cited in the literature: divorce narratives (Riessman, 1987); researching Gullah women (Beoku-Betts, 1994) and researching lesbian women (Hicks & Watston, 2003). Throughout this research I have been immersed in a period of reflexivity, actively seeking to address potential differences that may serve to challenge and thus affect both the negotiation of access to women following domestic violence, and the actual narrative interview. The dispensation of power afforded to me as the researcher and how this has been addressed for this study has been discussed in chapter three. However, the differences between the women participants (having lived with a perpetrator of domestic violence) and myself (not having such experiences) is more stark. In these terms I am an outsider, but this may have advantages: Hesse-Biber (2007) argues that it may be beneficial to be an outsider as this may negate perceptions of bias from the participants themselves and, further, that it might enable the researcher to gain new insights into the data as the lived experience of violence and resultant trauma is absent.

9.5 Development of the research field

Whilst this thesis presents new knowledge in the area of domestic violence, it also generates two significant further areas of inquiry to pursue.

1-The findings presented in chapter five revealed three specific tactics used by perpetrators during the early relational stage to engage a woman into a relationship which later became violent. Whilst Raven (1993) argues that coercion may require 'softening the target' (that is, the woman) and Dutton and Goodman (2005) argue that a 'stage has been set' for violent relationships, there is an dearth of literature about this early relational process. Therefore, a further study exploring the use of these tactics at an early relational stage is suggested. This may be beneficial to our understanding of whether these behaviours are considered cultural signifiers of romance or if they are intentional and specific behaviours used by perpetrators.

2-The literature presented in chapter two established the impact of domestic violence on a women's physical and psychological wellbeing. Despite this, there has been minimal attention afforded to how the physical effect of domestic violence impacts on a woman's perception of her body image. Weaver highlights that domestic violence may result in a full or zonal sensitivity to specific areas of a woman's body (Weaver, Resnick, Kokoska, & Etzel, 2007). However there is a lack of data regarding the impact of domestic violence on women's perceptions of their self, and the implications for breastfeeding. I suggest that this area of the research field is further explored and developed.

9.6 Conclusion

Epidemiological studies suggest that one in three women have experienced some form of domestic violence and, further, one in four have been abused whilst pregnant (United Nations Population Fund, 2000). Garcia-Moreno et al (2006) argue that during the antenatal and postpartum period the violence may commence or worsen with some studies suggesting prevalence rates of between 6 and 21 % in pregnancy, and between 13 and 21% in the post partum period (Campbell, et al., 2000). Synthesis of results from 13 studies found prevalence rates of domestic violence in pregnancy ranging between 0.9% (Sampselle, et al., 1992) and 20.1% (Gazmararian, et al., 1996). Rates of domestic violence associated with pregnancy also appear to be affected by the type of sample – community based or hospital based – and also the assessment tools that are used. Jasinski (2004) argues that these significant disparities in disclosure rates are attributable to differences in research methodologies and samples.

The first aim of the research study in this thesis was to explore the prevalence rates of reporting domestic violence by women in the immediate postnatal period. All these women were between 0 and 5 days postpartum and in hospital, therefore, they were not asked if they had experienced domestic violence in this postnatal period; rather, they were identifying if they had experienced violence during that pregnancy. The prevalence rate of domestic violence reported by the postnatal sample in the year they were pregnant (5.8%) is comparable to rates revealed by other studies (Campbell, et al., 2000; Sampselle, et al., 1992). Thus in isolation, these findings were limited. However, the postnatal study was one of several undertaken within a two year duration that replicated the use of the data collection tool, with the sample being drawn from the same geographical location (see Keeling, Birch & Green 2004 & Keeling & Birch 2004). Data from these other studies were available for comparison, and it is from these comparisons that new knowledge of the dynamics of

disclosure of domestic violence has been revealed. It appears that women in the immediate postnatal period are more reticent to disclose domestic violence than during other stages along the pregnancy/childbirth continuum, apart from Booking In Clinic.

A different trajectory emerged when analysing the data from the lifetime prevalence rate perspective. Using comparative data (see Keeling, Birch & Green 2004 & Keeling & Birch 2004), the results suggest that women are reluctant to disclose domestic violence when the pregnancy appears to be viable, and that the time of asking about domestic violence may critically affect whether a woman chooses to disclose. Hence, further research was generated into *how* and *why* specific periods within the pregnancy/childbirth journey inhibit a woman's desire to report domestic violence.

The 'generality' of coercive control (Schneider, 2000) defines domestic violence and may be subsumed under the four headings of violence, intimidation, isolation and control (Stark, 2007). These headings define specific aspects of a relationship in which domestic violence features, occurring once the perpetrator has engaged the woman within the relationship. The second research study presented in this thesis contributes further to this knowledge. Women's narratives of the engagement with a male partner in the early relational process, reveals how abusive relationships actually begin. The women's stories reveal subtle, defining and specific tactics used by perpetrators from the very outset of the relationship (section 5.2), from which he engages a woman into a relationship, with the intentionality of subjugation. Based on the women's descriptions of these tactics, they are termed 'feeling special', 'feeling vulnerable' and 'commitment'. Approximately one in four women globally have experienced domestic violence (United Nations Population Fund, 2000). I assert then that these rates are directly accountable to the perpetrator's behaviour and use of these specific tactics to successfully

form a relationship with a woman, with the intention of then using coercive and subjugating behaviours as described by Stark (2007). The emphasis lying within the domain of the man and his tactical behaviour may explain why so many women from differing socio-economic and cultural backgrounds experience similar levels of domestic violence.

Finally, the women's stories reveal how in contemporary society some professionals from within statutory agencies draw on social power and their professional behaviours use this power serving to continue the subjugation of women (chapters six, seven and eight). By focusing on women's experiences of oppression and exploring the 'mechanisms of domination' (Jagger, 1997: 188-193), the second study within the thesis also contributes to awareness of the social reality of women's domination by hearing the women talk of their attempts to access support from statutory agencies. Domination arises from within the statutory agencies themselves, as they are subject to privatisation and driven by market forces, with resulting tensions in how these professions are situated (Bondi and Laurie, 2005). Contemporary feminists argue that the welfare state plays a pivotal role in the support of women, with the National Health Service being the largest single employer of women and women being the primary recipients of welfare (Pateman, 1988). A significant barrier to both accessing and being supported by the welfare state, domestic violence perpetrators may limit a women's agency to obtain support and maintain employment as they often actively interfere with the woman's autonomy (Allard et al., 1997; Lloyd & Taluc, 1999).

Instead of the professionals providing support to women experiencing domestic violence, a parallel appears to exist between the behaviour of the abusive partner and the behaviours of these professionals. These behaviours include invalidation of the women's experiences and injuries, thereby inadvertently condoning the perpetrator's behaviour, and also holding the woman accountable for failing to safeguard her children, using threats to remove them into

care because of her inaction (chapter seven). This paradoxical relationship further undermines the woman's autonomy, isolating her further from accessing any form of help, which mimics the manipulation by the original perpetrator of violence. The research therefore challenges many of the current policies recently developed by statutory agencies to provide support for women experiencing domestic violence (Beresford, 2007; Department of Health, 2010b; Home Office, 2009). The women's narratives reveal that they come up against negative attitudes from the police force resulting in abridged legal proceedings against abusers, and social work responses that may be aligned to the controlling behaviours of the perpetrator (chapter eight). The acquiescent approach of health care practitioners may be disempowering to women by appearing complacent about their experiences. All these unconstructive actions appear to diminish a woman's desire to disclose her experiences of domestic violence and thus support the abuser's stance of control over his female partner (chapter six). The government argues for a multi-disciplinary approach to domestic violence, one that Wenger (1998) defines as a community of practice with three dimensions of joint enterprise, mutual engagement and shared repertoire. Despite the introduction of the MARAC (CAADA, 2012) board to facilitate this multi agency approach, further work is required to address the systematic failure of agencies in supporting marginalised women.

However, domination also arises from within the statutory agencies themselves, as they are subject to privatisation and driven by market forces, with resulting tensions in how these professions are situated (Bondi and Laurie, 2005). The statutory agencies are all gripped by privatisation, regulation and competition to ensure productivity gains and economic viability (Davies, Wright & Price, 2005). Whilst each agency seeks efficiency, the interplay between the complex set of factors within each agency to succeed is recognised. It is therefore vital that whilst addressing the individual behaviours of the statutory agency professionals, it is of

equal importance to agitate and challenge the cultural narrative within the regulatory professional context. The resultant opaqueness of professional's practice and lack of prioritising of women's experiences of domestic violence is apparent.

9.7 Recommendations

There are a number of key points derived from the findings that are presented as recommendations. The women's narratives included talk of their interaction with three statuary agencies: health service, law enforcement agency and social work practice. Therefore, to illuminate the recommendations concerning each agency, they are presented as separate points.

Health Service

1. It is recommended that health care services regularly review their policies in supporting women experiencing domestic violence to ensure that all areas of health and social care provision are engaging with, and implementing, these policies. Service users should be supported to positively engage in such reviews and audits through a process of formal induction and mentorship. The inclusion of service users on the training of health care professionals may illuminate the barriers to disclosure (see chapter 6, section 6.5.2) including the responses of the health professionals (Feder at el, 2006).
2. All health care practitioners need to recognise potential signs of domestic violence, and support women as part of a multidisciplinary team, enabling the provision of effective support and signposting ot other agencies.
3. Throughout the pregnancy/childbirth continuum, midwives should be astute in the recognition and provision of support to women experiencing domestic violence, and

be able to offer appropriate support and address issues concerning breast feeding (see chapter six). Additionally the midwives need to take a proactive stance towards asking women about their experiences of domestic violence, in a sensitive and appropriate manner.

Hester and Westmarland (2005) advocate routine enquiry, arguing that this approach is particularly effective in health care settings, positively affecting disclosure of domestic violence. Whilst only a minority of survivors of domestic violence are identified by health professionals (Feder, Hutson, Ramsay, & Taket, 2006), this is perhaps due to the acquiescent approach of health care professionals (see chapter 6).

Law enforcement agency

1. The professional training received by first response police officers needs to be consistent and radically different as the recent development of statutes does not appear to provide any benefits to women who initiate police involvement following domestic violence (see chapter 8, section 8.2.1).
2. The lack of consistency in police responses to domestic violence has been highlighted (Home Office, 2005), and can be addressed through point 4 of these recommendations.
3. An effective training programme should be developed and delivered by a consortium of statutory and voluntary representatives to provide a multi agency perspective on supporting women who experience domestic violence as advocated by the MARAC (Cadda, 2012).
4. To provide more effective and appropriate continuing professional development training around the issues of behavioural responses to women experiencing domestic violence, attitudes and assessment by the first response officer,

observations and support strategies, training should integrate the women (service users) themselves. Hearing women's stories of the issues of power, control and authority (see chapter eight, section 8.2.2) should facilitate law enforcement agencies understanding of how their socially ascribed role may mimic the tactical grooming used by perpetrators of domestic violence.

5. Cultural narratives within the regulatory professional context need reappraisal. A bifocal approach of organisational training days, in conjunction with the development of an academic award targeting those in positions of responsibility would promote a 'top down' approach to re-establishing and re-developing the cultural narratives within the law enforcement agency.
6. The recommendations detailed in these have already been established with the University of Bath (CAADA, 2012), providing credit bearing courses covering the core issues of domestic violence. Following evaluation of this education and training, the method could then be replicated throughout the Higher Education Institutions within the UK, thereby accessing and involving a large number of law enforcement agencies leading to a consistency in training.

Social Work Practice

1. It is crucial that social workers receive training to understand how to provide appropriate professional responses to women experiencing domestic violence. A programme of education is recommended to support social workers in addressing these issues. Integrating social work education into a Higher Education Institution facilitates access to research papers, evidenced based practice and should ensure the

provision of domestic violence into the undergraduate and postgraduate curriculum. Danis (2003) highlighted that social workers did not feel academically prepared to address domestic violence in practice.

2. Using specific learning tools within the training programme, such as reflective practice, role play and input from the service user perspective, will increase the recognition of their behaviours and how their inadvertent responses are perceived by women as being aligned with those of the perpetrators. I would suggest that social workers also undertake continuing professional development on domestic violence annually to ensure regular reinforcement of appropriate responses to women. Danis and Lockhart (2003) argue that through University provision of social work education, researchers can engage in creative problem solving approaches that incorporate and an amalgam of professionals, advocates and service users to develop appropriate strategies in the response to domestic violence by social workers.
3. Training should highlight the grooming tactics of perpetrators of domestic violence, so that social workers can understand how their own services and professional behaviours may reinforce trauma and helplessness in those seeking help.

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Appendix A: Domestic Violence data collection tools

Abuse Assessment Screen

"HITS" A domestic violence screening tool for use in the community (Sherin, 2003)

Merseyside Risk Identification Tool (MeRIT)

Name of victim:

BACKGROUND TO THE RELATIONSHIP

(If applicable include information on injuries to the victim and/or their demeanour)

ALL QUESTIONS MUST BE TICKED	Y	N

	ALL QUESTIONS MUST BE TICKED	Y	N
22			
23			
24			
25			
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WHAT HAPPENDED LEADING UP TO AND DURING THE INCIDENT

The Revised Conflict Tactics Scale (Straus & Gelles, 1990)

CAADA-DASH (Caada, 2009)

Appendix B: Patient Information Leaflet (Study 1)

You are invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Please do not discuss this research with anyone else in order not to jeopardise other women's safety.

What is the purpose of the study?

Domestic violence is extremely common in our society: approximately 1 in 4 women will experience it at some point in their lifetime. The majority of the violence, and the most severe and chronic, is perpetrated by men towards women and their children. The abusive behaviour women experience can have serious consequences on their health and wellbeing. Domestic abuse may start or become more severe during pregnancy. It may lead to miscarriage, placental separation or injury to the unborn child.

Why have I been chosen?

All women who have their baby at the [redacted] are being invited to participate in this research project.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are free to change your mind at any time. If you do not wish to complete any or this entire questionnaire, you can opt out, and this will not be detrimental to the care you receive.

What will happen to me if I take part?

You will be asked to complete a questionnaire on your own and in private whilst on the postnatal ward. A number will be used to protect your identity when accessing your maternity notes. This is only for the purpose of recording birth details. All the information will be kept in strict confidence at all times. We are aware of the sensitive nature of this subject and also your safety and therefore a list of support numbers are provided that you may wish to use in confidence.

What will I have to do?

All you will have to do is complete a short questionnaire with tick boxes for answers, and return it in the envelope that accompanies it.

What are the disadvantages of taking part?

The questionnaires will take a few minutes to complete on one occasion.

What are the advantages of taking part?
This is a very important piece of research for all pregnant women and their babies. Your contribution is greatly valued. The information you give us will help us understand the issues around domestic abuse, and the impact that it has on the health of a pregnant woman and her baby.

What happens when the research stops?
On completion of the project and following analysis of the data, this information will be destroyed.

Will my taking part in this study be kept confidential?
All the information collected will be kept strictly confidential. The researcher will access your maternity notes, with your permission, to record basic details about your maternity care and delivery.

What will happen to the results of the research study?
It is anticipated that the research will be in progress for six months. The results should be available two years after its completion.

Who has reviewed the study?
The Wirral Ethics Committee has approved this research.

Contact for further information
If you would like any further information, please contact telephone

Where can I go to get help?
Family Protection Unit [redacted]
Women's Aid 24 hour Help Line 01925 220541
Contact a midwife (24 hour) [redacted]

Confidentiality is assured

Thank you for your help on completing this.

Appendix C: Applying to the Faculty of Health and Social Care Research Ethics Committee (Study 2)

University of Chester
Faculty of Health and Social Care
Research Ethics Committee

Application form

Please use the guidance notes to assist you in completing this application for ethical approval. The boxes will automatically enlarge to allow you to complete each section as fully as possible.

1. Name of lead researcher and applicant [please attach CV]
June Keeling

2. Contact details

Address
Work:
Daytime
Home *Please use home address for all correspondence
Daytime phone:
Mobile
e-mail address j.keeling@chester.ac.uk

3. Full and short title

Full title: Using storytelling to explore women's experiences of Interpersonal Violence

Short title:

4. Additional researchers

5. Supervisory/mentoring arrangements
This research study will be undertaken as partial fulfilment of the PhD programme. Supervisory support will be provided by Prof. M. Thomas, Prof. E Mason-Whitehead and Prof. T. Mason.

6. Have you obtained/will you require ethical approval from another source?
No

7. Research outline , including:

- **Brief outline of study, aims and objectives**

The study uses a qualitative approach to explore the lived experience of domestically abused women.

Intimate Partner Violence (IPV) in women is a gender specific issue in that the male perpetrator has exerted power and control over his female partner. Thus, as a female researcher with her own belief and attitude to gender based violence, an empowerment feminist methodology encapsulating the central tenets of feminism and the subjective experience of engaging and interviewing women will be used (Ribbens & Edwards, 1998). Elaine Lawless (1993) in her work on feminist theology purposed that male constructs applied to women's stories make it more challenging for women to identify and construct their personal story, thereby emphasising the need to find a construct that fully embraces the complexities of women's lives as they experience them. A feminist methodology respects the autonomy of women, and addresses the potential power imbalance of researcher dominance which may occur in an interview (Cotterill, 1992). The participants are, or have been, resident in a women's refuge and are in a place of safety, receiving emotional support and practical help to re-establish themselves. The researcher will arrange an informal meeting with any woman who is interested in the study. Each woman will receive a Participant Information Sheet and have the opportunity to ask the researcher any questions about the study prior to agreeing to take part. This meeting will take place within the refuge. Thus, the safety of the woman and the researcher will be maintained. A contact number for woman agreeing to take part will be recorded. Following at least a twenty four time period elapse, the researcher will re-contact these women to arrange a mutually convenient date to meet.

The Research Aim

1. To understand the role of violence in the lives of a group of women
2. To gain a deeper understanding of the experiences of women living with an abuser and the complex interrelationship of being both pregnant and abused, in the context of women's lives.
3. To explore factors that may impact on a woman's willingness to disclose domestic abuse when pregnant and following childbirth.

- **Study timings**

See Gantt Chart

- **Data collection, analysis and rationale**

Data collection will be through storytelling. The narrative interview will enable the woman participant to develop her own story, reconstruct it and relive their experiences, with very few questions being asked by the researcher (Holloway, 2008). Each narrative interview will last for as long as the woman chooses and will be conducted within a private room within the refuge. Where necessary childcare will be provided by the refuge child worker to enable the woman to speak freely. The use of a sensitive and ethical manner will be adopted throughout and by choosing a flexible approach whilst listening attentively, this will enable the woman to lead the interaction and line of discussion regarding her life story (Stanley & Wise 1990). The use of story telling enables the narrative to be contextualised and is considered to be a feminist approach to qualitative research (Wolf, 1996). The narrative will capture the woman's lived experience of abuse and how she has experienced the world as a victim of abuse (Carter, 1993). The use of power and control by the interviewer may negate any feelings of empowerment thus the feminist approach to data collection, enabling the woman herself to direct the interview, which will avoid any further control or exploitation (Josselson & Lieblich, 1999). Each woman will allocate herself a pseudonym to maintain confidentiality, and will direct the interview, deciding when to end it. The researcher will

refer to prompts as necessary but it will be clear to the woman that she may choose the discussion pathway and when to terminate the meeting. This will encouarge an open exploration of the woman's life journey, rather than through the linear questioning approach of interviews considered patriarchal (Ribbens & Edwards, 1998). With the participant's permission the interview will be digitally tape recorded and transcribed verbatim by the researcher. To ensure the research is rigorous and trustworthy, the transcription will be returned to the woman via communication of her choice (email, post etc).

The interview will typically start with 'Please could you tell me about your life'. This intial part of the interview will be to encourage the woman to feel more comfortable about talking. The researcher will only encourage the woman to talk for as long as she wishes, and about any period of her life, this being dependent on what she chooses to disclose.

A pilot study of two interviews followed by analysis will be undertaken before the main study commences.

Transcription

A recognition of the complexities of the research process, and the questioning of it, are fundamental elements of feminist methodological research (Tilley, 2003; Wolf, 1996), including the transcription process. Tilley (2003) questioned the role of the transcriber during the transcription process in qualitative research, identifying that active participation in this process could enhance educational learning. Furthermore, Gilchrist (1995) in her experiences of researching Aboriginal youth identified how large amounts of data may be lost in the transcription process if the transcriber does not understand what is being said. Both Knupfer (1996) and Tilley (2003) have referred to the fact that re-listening to women's voices draws them back into the participants' worlds. Tilley (2003) identifies that the transcriber's interpretation of the dialogue within an interview is reflected in the typed transcription. Scheurich (1995) further states that data analysis is an interpretation of reality by the researcher, in response to the data.

The tape recorded interviews will thus be transcribed verbatim by the researcher within forty eight hours of collecting the data, and before commencing the subsequent interview, to ensure the richness of the data is captured. Gubrium & Holstein (2009) identify that in narrative reality the aim is to capture the maximum amount of verbatim detail possible to later provide in vivo examples of narrative. Brief notes may be made during transcription to record any unusual points to specifically explore when analysing the narrative.

Data analysis

The researcher will explore the data through narrative analysis. It is recognised that there are several different types of narrative analysis. However for this study a feminist approach will be integrated into narrative analysis, as described by Bell (1998) and Reissman (1993). Narrative analysis is an analysis of a personal chronological story, told from the participant's viewpoint. It focuses on the stories of a participant more than other research methods, and thus may be considered an empowering social science methodology giving respondents an opportunity to articulate their own viewpoints (Holloway, 2008; Gubrium & Holstein, 2009). The life story method of narrative analysis involves interviewing a woman and then retelling her story as if written by them (Reissman, 1993). Bell (1998) describes story analysis as a sequence of stories that provides an insight into a woman's personal experience. Kay Standing (1998, as cited in Ribbens and Edwards, 1998) identifies the paradox of accurately

representing women's voices whilst maintaining an academic audience. However, Opie (1992) identifies that by giving 'socially marginalised' women a voice, this in itself is empowerment.

- **Type of participant**

All participants will be women who are currently/have been resident within a women's refuge in the [redacted]. Using random purposive sampling with voluntary participation, ten women will be involved in the study.

- **Attach consent forms, questionnaires etc**

(See Appendix B for consent form)

Resources:

Digital Tape Recorder (hired from McArdle Library)
NVIVO - obtained through University of Chester
Laptop with Windows 2007
Time - Study leave being taken to complete data collection phase of study

This should not exceed 1000 words

8. Summary of ethical issues – please address all the headings, even if it is to reassure the committee that it is not applicable. The guidance notes contain further information to help you complete this section

An interview is a process of interaction between the researcher and the participant that is based on mutual confidence (Yassour-Borochowitz, 2004). The key ethics of this project lies in absolute equal roles both the women (researcher and participant) have in the interview. IPV is an emotive subject which may present danger to both the researcher and participants. Therefore the utmost due care and attention has been given to the ethical procedures and methodology of this study. A feminist approach to ethics has been integral in the exploration and identification of the ethical issues specific to this study, to ensure concordance within a feminist methodological framework.

- **Participant recruitment, criteria, reimbursement and relationship**

The random voluntary system of self-selection for this study will be through the women actively choosing to meet the researcher I order to take part. The process of invitation will be through a Participant Information Sheet distributed to women aged over 18 who are currently residents/prior residents of the refuge, informing them of the study and inviting them to meet the researcher in the meeting room within the refuge if interested. Participation will be entirely voluntary. It is important to identify to the women that the study is entirely independent of the refuge and their care will not be affected through a refusal to participate. If agreeing to participate, a mutually convenient time to meet within the refuge will then be arranged. However this will be at least 24 hours after the initial meeting in order to give the participant time to reflect on their decision. At this following meeting verbal consent to participate will be obtained. There will be no reimbursement for participation

- **Potential benefits for participants**

Using the narratives of women's stories, it is anticipated that a greater understanding of the coping mechanisms women employ when living with an abuser, and how they experience the

world, will be obtained. Using a retrospective approach by talking to women after they have left their abusive partner, it is hoped the depth of data generated will lead us to a better understanding of these issues. This will increase the knowledge and awareness of health care professionals and positively impact on the provision of health care.

- **Informed consent and confidentiality**

Each participant has the right to make their own decision regarding participation. Verbal consent only will be obtained from the participants. This approach is more usual when researching IPV and maintains the safety of both the participant and the researcher. The participant will be informed that they are able to withdraw from the research at any time with no adverse effect. Confidentially will be guaranteed.

- **Risk management**

1. The risk of a perpetrator discovering his partner has participated in research. This will be addressed by only accessing women who are being supported by a women's refuge, and have therefore left their abusive relationship. The manager of the refuge (who has, and is currently providing support for these women) will initially invite the women to meet the researcher. Only the first name of the woman will be known on introduction. To ensure anonymity is maintained, any woman who agrees to participate will chose a pseudonym by which to be known. It is anticipated that verbal consent will be obtained prior to participation and not written consent.
2. Safety of the researcher and potential for harm from a perpetrator. The manager of the refuge will be the first point of contact with the women and has agreed to invite them to meet the researcher within the refuge. This in itself is a place of safety. It is here that the researcher will discuss the study and invite the women to participate. All interviews will take place within the refuge at a mutually convenient time. No contact will be made with any partner of abuse.

- **Avoidance of harm and distress**

The researcher will be meeting women who are in the process of recovery and enlightenment, and to prevent further emotional harm, a feminist approach to the data collection will ensure that the woman chooses what she would like to disclose and interrupt the interview at any time, perhaps to resume at a later stage or to terminate the meeting. Ongoing emotional support following the interview will be continued by refuge personnel. It has been suggested that the process of cognitive restructuring is enhanced by repeated narrative construction (Holmes, Alpers, Ismailji, Classen, Wales, Cheasty, Miller, Koopman, 2007) and this has a further positive impact on women's physical health (Pennebaker, Mayne & Francis, 1997).

- **Management of data**

All data will be managed in accordance with the Data Management Act (2003).

The tape recorded narrative will be transcribed by the researcher and then password protected on the [redacted]. This laptop is kept [redacted] with only the researcher having access to it. As pseudonyms are being used throughout, no personal information will be identified. The recorded transcripts will be kept [redacted] in a place of safety until completion and publication of the PhD. They will then be destroyed.

- **Vulnerable groups**

This research study will be accessing marginalised women who have been living in an abusive relationship. Thus several considerations are necessary. Feminists have argued that a woman researcher may have more power than a woman participant, though Cotterill (1992) suggests that the power balance within interviews is dynamic in that both the researcher and participant may be vulnerable. To facilitate equity within the interview the women participants will remain in control of the date and time of an interview and this is a fluid arrangement.

1. The initial invitation to meet the researcher at the refuge will be made by the refuge manager, thus the initial decision lies within the domain of the woman.
2. Each woman who agrees to participate will decide on a pseudonym by which she will be known throughout the research study.
3. Autonomy of the woman will be maintained by empowering her to terminate the interview when she chooses.
4. Non maleficence: it has been considered and discussed with the refuge manager of the responsibility to prevent any further psychological distress. Through the use of storytelling, the woman will be able to decide how much information to share with the researcher. Furthermore the refuge personnel through counselling and workshops will be able to provide ongoing emotional support following the interview if required.
5. It will be made clear that this study is independent to the refuge, and choosing not to take part will in no way affect the support received by the refuge personnel.
6. Provision of child care is intrinsic in refuge care; therefore this will be further accessed allowing any woman who participates to openly discuss their experiences in the absence of children.
7. The research is being supported by the managers of the women's refuges.

This should not exceed 1000 words

9. Form RO1

I have completed a Form RO1 No
(If Yes, please attach a copy to this application for reference)

10. Signatures

I confirm that to the best of my knowledge, I have accurately provided all the relevant information to the RESC for their consideration of your proposal. I also agree to provide a supplementary application if it becomes necessary to utilise additional data collection methods and to inform the RESC if the nature of my proposed study changes significantly.

Signature…… Date…….

- If you are a student, please ask your supervisor to sign and date your application to indicate that their approval of your proposal.

Supervisor's signature …….
Date…….

Appendix D: Participant information sheet (Study 2)

Using storytelling to explore women's experiences of Interpersonal Violence

My name is June and I have previously worked as a midwife and nurse within a hospital. I am now carrying out a research study and would like to invite you to take part. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

- What is the purpose of the study?
  The purpose of this study is to understand what it is like to live with an abusive partner.

- Why have I been chosen?
  This research aims to help Health Professionals (e.g. midwives and doctors) to have a better understanding of domestic abuse, therefore it is very important that women who have experienced this take part.

- Do I have to take part?
  You do not have to take part. This will not affect the care and support you receive from the refuge in any way. If you do decide to take part in this study, you are able to change your mind at any time.

- What will happen to me if I take part?
  If you agree to take part, I will arrange to meet you at a time that suits you. I will ask you if you would be happy to have a chat about your life experiences.

- What are the possible disadvantages and risks of taking part?
  During our conversation there may be a risk of you becoming upset as you recall life events. Should this happen you may wish to choose to stop the meeting (either permanently or return to it another time). Emotional support is offered by the Refuge Staff and is freely accessible to you.

  Any information that you choose to share with me will be kept confidential. You may decide on a pseudonym (false name) by which to be identified or I can help you to decide on one if you wish. Any other names mentioned in the discussion will be changed.

- What are the possible benefits of taking part?
  The benefits to taking part will be to help Health Professionals to gain a better insight and understanding into how to support women more appropriately when they are living with an abusive partner.

- Will my taking part in the study be kept confidential?
  All information will be kept confidential at all times. Any names mentioned will be changed. Apart from my supervisors and me, no-one else will have access to any information.

- What will happen to the results of the research study?
  It is hoped that the results can be shared with relevant Health Professionals to assist them in providing better support for women.

- Who is organising and funding the research?
  The organiser of the research is named above. There is no funding for this research.

- Who may I contact for further information?
  You may contact June Keeling on 0151 [redacted] or j.keeling@chester.ac.uk

Thank you for your interest in this research.